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ABSTRACT

Transitioning from individual to family counseling can be difficult because, as one moves between these two approaches to helping, it becomes necessary to view all aspects of behavior differently. This monograph offers a sampling of professional views on the various challenges confronting a counselor in such a transition. Essays include: (1) "Family Counselors as Artists and Scientists" (Samuel T. Gladding); (2) "Equilibrium: A Conceptual Context for Family Counseling" (Peter A. Powers and Charles H. Huber); (3) "Family-of-Origin Work for the Family Counselor" (Volker Thomas and Phil Striegel); (4) "Cultivating the Language of Play: The Young Child in Family Counseling" (C. Wayne Jones); (5) "Mexican-American Families and Acculturation: Implications for Family Counseling" (Sylvia Soto-Fulp and others); (6) "Community as Family: The Multiple-Family Contexts of Gay and Lesbian Clients" (Darryl Dahlheimer and Jennifer Feigal); (7) "Family Counseling without the Family: Working with an Individual Client" (Patricia G. Driskill); (8) "The Family-School Intervention Team (FSIT) Model: A Metalevel and Multisystemic Approach" (William H. Quinn); (9) "Individual to Family-Systems Thinking in the Health-Care Context" (Kathy Cole Kelly); (10) "Playing with Contextual Complexity: Relational Consultation with Family Businesses" (Douglas G. Flemons and Patricia M. Cole); and (11) "Family Counseling in a Private-Practice Setting: An Interview with Frederick Brewster" (Charles H. Huber). (RJM)

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THE FAMILY PSYCHOLOGY AND COUNSELING SERIES

ED 403 519

Transitioning from Individual to Family Counseling

edited by
Charles H. Huber

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series editor
Jon Carlson

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TRANSITIONING FROM INDIVIDUAL TO FAMILY COUNSELING

Edited by Charles H. Huber

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■ ■ ■

THE FAMILY PSYCHOLOGY AND COUNSELING SERIES
Jon Carlson, Editor

Transitioning from Individual to Family Counseling

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American Counseling Association
5999 Stevenson Avenue
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Director of Communications
Jennifer L. Sacks

Acquisitions and Development Editor
Carolyn Baker

Production/Design Manager
Michael Comlish

Copyeditor
Heather Jefferson

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From the Series Editor

Transitioning from individual to family counseling can be difficult because, as one moves between the two approaches to helping, it becomes necessary to view all aspects of behavior differently. In this monograph, a wide sampling of professionals present the various challenges when changing one's viewpoint from an individual to a family-systems perspective. The similarities and differences of seeing family counseling as both art and science point to a helpful distinction, as does the discussion of how individual therapists are more concerned with adjustment, whereas for family counselors the term *equilibrium* seems to work more effectively. Counselors must use different languages and forms of communication, such as play, when working with a family. Huber and his colleagues discuss the various contexts in which family counseling occurs, including: (a) schools, (b) health care, (c) private practice, and (d) business settings. Cultural influences are well represented in the selections on Mexican–American and gay and lesbian relationships, as well as understanding one's own family of origin. A chapter on family counseling with only one family member present is an idea that has only recently gained acceptance. The final chapter of this book, an interview with Frederick Brewster, describes the double life of counselors in private-practice settings. This excellent compilation of chapters is important reading for all who have been trained with an individual orientation who find themselves now practicing in the family context.

—Jon Carlson
Series Editor

Preface

The past three decades have seen an exponential growth in the number of mental health professionals embracing a family-counseling perspective: an emphasis focusing therapeutic efforts on the family system rather than on individual family members or an individual client. Although this perspective finds meaning in the symptoms exhibited by the individual, these manifestations are viewed as covariate aspects of family relationships. Consequently, the client becomes the family system including the individual, rather than the individual in isolation; interventions target improvement in the overall family functioning or in specific intrafamily relationships as well as an individual member's symptoms.

Although family counseling has been adopted by many, the dominant mode of mental health training still remains individually oriented counseling and psychotherapy. Individually oriented professionals and professionals in training represent the majority of future family-counseling practitioners. Transitioning from an individual perspective to a family-counseling perspective (that includes the individual) has been, and promises to continue to be, a mental health training focus for some time.

This book offers a pragmatic perspective on *Transitioning from Individual to Family Counseling.* Three parts—the first composed of three chapters and the latter two each composed of four chapters—provide a framework for professionals in training as well as transitioning professionals in practice. Part I addresses essential elements to consider in assuming the role of a family counselor. Part II looks at working with various client populations from a family-counseling perspective. Part III examines several treatment contexts, illustrating the impact of a family-counseling orientation within each. Case illustrations and insights from practicing professionals highlight each chapter.

It is my hope and those of the contributing authors that this book provides a helpful learning context for those "transitioning" to, as well as those seeking review and reconsolidation of, the concepts underpinning a family-counseling perspective.

—Charles H. Huber, PhD
Editor

Biographies

Charles H. Huber is presently on the faculty in the Department of Counseling and Educational Psychology, New Mexico State University. A licensed psychologist in the states of Florida and New Mexico, he also hold diplomates in Family Psychology and Behavioral Psychology with the American Board of Professional Psychology. In addition, Dr. Huber is a clinical member and approved supervisor of the American Association for Marriage and Family Therapy, a clinical mental health counselor and approved supervisor of the Academy of Mental Health Counselors, and a fellow and approved supervisor of the Institute for Rational-Emotive Therapy. He maintains a private practice with Associates for Marriage and Family Therapy in Las Cruces.

Dr. Huber received his BA from Upsala College, his MEd and EdS from Florida Atlantic University, and his PhD from the University of South Carolina. He has authored or co-authored 10 books, served as editor of several professional journals, and written numerous articles and book chapters as well. He is active in a number of professional organizations, most recently serving as president of the New Mexico Association for Marriage and Family Therapy. Dr. Huber has been married for almost two decades to his partner, Betsy. They and their two children raise and train Labrador retrievers as their family hobby.

Jon Carlson, PsyD, EdD, is Distinguished Professor at Governors State University in University Park, Illinois, and director of the Lake Geneva, Wisconsin Wellness Clinic. Dr. Carlson has served as the president of the International Association of Marriage and Family Counselors. He has authored 16 books and over 100 professional articles. He serves as the editor of *Individual Psychology: The Journal of Adlerian Theory, Research, and Practice*, as well as *The Family Journal.* He holds a diplomate in Family Psychology from the American Board of Professional Psychology. He is a Fellow of the American Psychological Association, a clinical member of AAMFT, and a certified sex therapist by AASECT. He has received awards for his professional contributions from the American Counseling Association, American Psychological Association, North American Society of Adlerian Psychology, and the International Association of Marriage and Family Counselors. Dr. Carlson and his wife of 25 years, Laura, are the parents of five children.

Contributors

Patricia M. Cole is a PhD candidate and research assistant in the School of Social and Systemic Studies, Nova University, Ft. Lauderdale, Florida.

Kathy Cole-Kelly, MS, MSW, is director of Behavioral Sciences, Metro-Health Medical Center, Cleveland, Ohio.

Darryl Dahlheimer, MSW, ACSW, is in private practice in Minneapolis, Minnesota.

Diana S. DelCampo, PhD, is associate professor of Cooperative Extension Service, New Mexico State University, Las Cruces, New Mexico.

Robert DelCampo, PhD, is professor of Family Science, New Mexico State University, Las Cruces, New Mexico.

Damond Dotson is a doctoral candidate in the Marriage and Family Therapy Program, Department of Child and Family Development, University of Georgia, Athens, Georgia.

Patricia Driskill, PhD, is a psychologist with the Abernathy Independent School District, Abernathy, Texas.

Jennifer Feigal, MSW, ACSW, is in private practice in Minneapolis, Minnesota.

Douglas Flemons, PhD, is assistant professor in the School of Social and Systemic Studies, Nova University, Ft. Lauderdale, Florida.

Samuel T. Gladding, PhD, is professor of Counselor Education, Wake Forest University, Winston-Salem, North Carolina.

Jane Hill is a doctoral candidate in the Marriage and Family Therapy Program, Department of Child and Family Development, University of Georgia, Athens, Georgia.

Charles H. Huber, PhD, is professor of Counseling and Educational Psychology, New Mexico State University, Las Cruces, New Mexico.

C. Wayne Jones, PhD, is a senior faculty member in the Family Therapy Training Center at the Philadelphia Child Guidance Center, Philadelphia, Pennsylvania.

Peter Powers, MEd, is a doctoral student in the Counseling Psychology Program at New Mexico State University, Las Cruces, New Mexico.

William H. Quinn, PhD, is associate professor of Child and Family Development and director of the Marriage and Family Therapy Program, University of Georgia, Athens, Georgia.

Sylvia Soto–Fulp, MS, is a doctoral student in the Counseling Psychology Program at New Mexico State University, Las Cruces, New Mexico.

Phil Striegel, MA, is a doctoral student in the Marriage and Family Therapy Program at the University of Iowa, Iowa City, Iowa.

Volker K. Thomas, PhD, is assistant professor of Counselor Education, University of Iowa, Iowa City, Iowa.

Gail Wiley is a doctoral candidate in the Marriage and Family Therapy Program, Department of Child and Family Development, University of Georgia, Athens, Georgia.

PART I

THE COUNSELOR

1

Family Counselors as Artists and Scientists

Samuel T. Gladding
Wake Forest University

The process of family counseling is both an art and a science. Like artists, family counselors must concentrate their attention so that the work they do is focused and significant. In addition, family counselors, like artists, must be inventive and creative in applying their skills and resources to situations that are unique but also universal. Counselors must be playful and improvisational in the complex process of promoting change, just as artists must utilize their most healthy childlike traits in bringing life to the canvases, pages, and characters they try to transform (Gladding, 1992; Papp, 1984).

Family counselors also need to be scientists and scientific. They must insist that their work with families be held up to scrutiny by other mental health professionals and avoid mystifying the change process. They must subject their procedures to standard research analyses, such as tests for reliability and validity. In short, they must incorporate scientific procedures into their methodologies. When this occurs, their skill as practitioners becomes rigorous, and the speciality of family counseling gains respectability as a way of helping (Nichols & Schwartz, 1991).

The practice of most family counselors demonstrates that the art and science of helping are complementary, not competing, forces. Artistic endeavor is the basis for innovation and invites scientific exploration. Likewise, scientific affirmation of novel procedures is the means for developing more artistic therapeutic methods.

In this chapter, the contributions of art and science to family counseling are highlighted separately and collectively. How creative art endeavors contribute to family counseling is explored first. The scientific underpinnings of family counseling are featured next. Finally, the shared values and complementary nature of the art and science of family counseling are discussed. Just as the process of becoming a skilled craftsperson takes years of practice and dedication, the struggle to master the use of the art and science of family counseling is one that only occurs through time and effort (Cavanagh, 1982; Cormier & Cormier, 1991). It is imperative that family practitioners be aware of both the artistic and scientific dimensions of their work and utilize both to the fullest. Through such an effort, awareness is enhanced and the caliber of services offered to client families improves.

The Art of Family Counseling

The art of family counseling is defined in this chapter as the creative and unique ways that counselors employ in helping families. Sometimes this art utilizes recognized arts, such as music, literature, drawing, or drama, as adjuncts (Gladding, 1992). At other times, the process of having families interact in novel ways is the main tool utilized (Satir, 1982). As a general rule, the art of family counseling is the flexibility and creativity of counselors in working with their client families.

A major contribution of the art of family counseling, regardless of form, is its emphasis on emotion. Art is at the heart of family counseling because it deals with the expression of feelings. Much of family life is lived, for better or worse, on the affective level (Satir, 1982). Among other activities, family members laugh, cry, get mad at, and love each other. Goodyear and Bradley (1981) summarized research that supports the primacy of affect in human interactions. The ways family members learn to express their emotions goes a long way in either hindering or helping promote their unity or diversity. In working with families, it is essential that counselors address emotions as well as actions (Wood & Jacobson, 1990). By using the arts, family counselors can help families learn more about what they are feeling and enable them to find novel, appropriate, and supportive ways to express themselves (Gladding, 1992; Johnson, 1991).

A second contribution of the art of family counseling is that it allows therapeutic practitioners to become creative and innovative with their clients (May, 1967). "Family therapists have discovered that to impact on the complex family system, powerful and often intrusive techniques are required" (Johnson, 1991, p. 187). The origins of strategic family counseling, especially the techniques within this approach formulated by Cloe Madanes, are an example of the freedom found within artistic traditions. These methods help break down resistance and circumvent defenses.

A third way the art of family counseling helps is through assisting clients to gain perspective. The function of both art and counseling is "to change people's ways of looking at themselves, the world, and the human condition" (Pittman, 1992, p. 126). Creative professionals such as Milton Erickson, Virginia Satir, Peggy Papp, and Bunny Duhl have demonstrated an uncanny ability to be artistic in getting families to see the world from a different angle. It is an art for practitioners to bring about a change in the outlooks of those with whom they work. A different view of the world can often lead to changes within family interactions because situations are seen as less serious and more hopeful (Watzlawick, 1976, 1978, 1983).

Yet, a fourth contribution of the art of family counseling to the overall field of family counseling is that it allows scientific practitioners to express truth in a palatable way. Family members are more likely to hear what is being said and therefore more likely to act. For instance, Friedman (1990) has written a number of tales that deal with important aspects of counseling and family life. By using the artistic medium of storytelling, he has been able to attract a wide readership and get people to think about events in a way he never could have done had he used scientific language.

Likewise, the artistic use of humor in family-counseling sessions can help reduce resistance and enable family members to hear each other and their counselor. They are thereby enabled to consider alternative ways of interacting. The results are the creation of a reframed atmosphere in which "people can consider themselves more objectively than if they are 'out of control' " (Barton & Alexander, 1981, p. 431).

A fifth contribution of the art of family counseling to the general field of family counseling is that it allows the collective wisdom of the ages about relationships to be passed on. For instance, in the work of Rubinstein (1990), excerpts from different types of literature (e.g., poetry, novels, plays) are quoted as they relate to the developmental stages of marriage, such as newlyweds and mid-life couples. A unique feature of this book is that it encompasses literature across the ages of civilization and combines the best of ancient wisdom with that of the new. Chavis (1987) also used literature—modern short stories—to depict stages of family life. She does not give "answers," but provides thought-provoking literature that stands on its own merits in addressing important family issues that must be successfully resolved. In this subtle, indirect manner, she helps practitioners and the lay public gain insight and chart directions for their own lives.

A sixth and final contribution of the art of family counseling is that it has allowed family counselors to express the artistic side of their personalities. This freedom has been therapeutic for some clinicians and has been enlightening for clients. For instance, Napier's (1989) autobiography, *The Fragile Bond*, detailed events of his life that influenced his development as a professional and a person. His book is unique in its inclusion of marriage and family life in a detailed and vivid manner. It offers behind-the-scenes accounts and insight into the difficulty and success of balancing a career with a marriage.

The Science of Family Counseling

The science of family counseling is its more objective and detailed side. It is like the mind of the profession in the way it processes information on a cognitive level. Science encompasses the thinking, rational, and logical part of treating families. It is the means by which plans are made and carried through. The scientific method and the respectability of scientific ways of conceptualizing and evaluating family counseling have led to the growth of the profession (Barker, 1986).

One of the most valuable contributions of the science of family counseling is respect. Science has made the theory and methods of treating families definable in a uniform manner (Segal, 1991). For instance, Minuchin (1974) compared the work of a structural family counselor to that of "a technician with a zoom lens." The counselor "can zoom in for a closeup . . . but can also observe with a broader focus" (Minuchin, 1974, p. 3). Other family-counseling theorists, especially behaviorists, have used scientific analogies and methods in an even more rigorous manner.

A second contribution of the science of family counseling to the field as a whole involves communication. Scientific language allows researchers and clinicians to inform each other about the factors that bring about change within family treatments (Sprenkle, 1990). For instance, Minuchin defined the techniques of structural family counseling in such a way that both novice and experienced family counselors alike can discern the meaning and application of these methods (Minuchin & Fishman, 1981).

A third contribution of the science of family counseling is that it validates through research what is occurring in families and what areas need to be addressed. For example, research shows that for healthy and functional familial relationships, it is vital to establish (a) fairness, (b) tolerance, (c) trust, and (d) open communication among family members (Lewis, Beavers, Gossett, & Phillips, 1976; Stinnett & DeFrain, 1985). Without these qualities, families play zero-sum games where one member of a family gains power by putting down another member. In the process, everyone loses because the person who is hurt usually seeks revenge in subtle or overt ways. Family members who do not realize this dynamic about deep relationships become destructive and continue downward patterns that are virtually unending (Watzlawick, 1983).

Family counseling has been viewed as projecting a lot of intuitive appeal, and it is on the basis of this attractiveness that many practitioners have conducted their experiences (Nichols & Schwartz, 1991). Yet intuition is not enough. That is where the science of family counseling makes a fourth contribution to the field. Science and the scientific method require that clinical work be rigorous (i.e., tightly controlled). This type of rigor ensures that methods are similar each time counseling occurs. Science standardizes the uniformity of practice. It is an essential element for the field of family counseling to have, especially within education and supervision programs.

A fifth contribution of the science of family counseling is reliability. To say that a process is reliable is to state that it is consistent or dependable (Miller, 1986). Reliability ensures that what a family counselor did with a family can be done again. For example, if counselors get family members to contract to do specific behaviors and the family dynamics change, it is essential that other counselors be able to conduct this procedure with similar families and obtain the same type of results. In other words, it is crucial that family counselors be able to prove that the techniques of their theories work. Scientific research is the only way to verify that this occurs.

The sixth and final contribution of the science of family counseling is the ability of scientific research to show anomalies and failures and, in the process, to challenge researchers/practitioners to find new ways to help families. Science works in the interest of assisting creative clinicians find effective, novel intervention methods with families. In essence, science promotes the building of new paradigms for treatment.

Shared Characteristics of the Art and Science of Family Counseling

As defined by Burke (1989), art and science in therapeutic settings share four fundamental characteristics: "honesty, parsimony, duality, and insight. These qualities characterize both good art and good science and can be considered measures of their value" (p. 27). In addition, art and science in the service of counseling lead to better communications in the field and the continued development of therapeutic theories and practices. Each of these six complementary traits are discussed briefly.

1. *Honesty.* Good art and science are honest in what they produce. At its best, art conveys some fundamental truth about the human experience that moves its consumer emotionally. Science demonstrates factual information that is truthful to human experience also. It does so through careful research and openness to replication and generalization. Therapeutically, honest clinicians are genuine and authentic with themselves and their family clients, whether they operate from primarily an artistic or a scientific base.
2. *Parsimony.* Art and science are simple and straightforward in the ways they address topics. They convey information in the most effective ways possible. They do not exaggerate or underplay results. Therapeutically, parsimonious clinicians are direct and/or creative in the ways that maximize their impact and bring about change.
3. *Duality.* The third trait that art and science share in therapeutic settings is duality. The essence of duality is the ability to see both sides of a situation. Family practitioners must exercise duality so that they are balanced: sensitive and caring. Duality also allows them to be focused and tough-minded enough to stay with clients until appropriate progress has been made.
4. *Insight.* Both art and science in family counseling give counselors and families insight. This common dimension is characterized as new knowledge based on previous learning. It promotes understanding. In clinical settings, especially with families, practitioners need to be aware of what they can do to understand clients fully and overcome client barriers to change. The procedures and processes they use are ones based on their ability to combine or restructure information they already possess so that new ideas or perceptions are generated and utilized.
5. *Communication.* A fifth common characteristic of art and science in counseling is the ability these ways of conceptualizing

enable professionals to share concerns and ideas with their colleagues. Such knowledge is often conveyed in the language of metaphor, making it possible for practitioners of all persuasions to speak and be heard on an understandable level (Barker, 1986; Becvar & Becvar, 1993; Mills & Crowley, 1986).

6. *Development.* The art and science of family counseling promote the expansion and development of treatment. Without the interaction of the artistic and scientific perspectives with each other, the field of family counseling is greatly restricted. Professionals who are artistic in their practice with families give scientific researchers an opportunity to verify or disconfirm their procedures. In fact, one of the aims of "scientific creativity has been to recapture the different phases of thinking that lead to the creative act" (Arieti, 1976, p. 268). Scientifically based clinicians point out aspects of treatment that need refinement or correction. Being a competent family counselor means knowing how to utilize and integrate the range of artistic and scientific theories and techniques (Gladding, 1992; Napier & Whitaker, 1978).

Conclusion

Family counseling is rich in the art and science of theories and techniques that stress change and promote growth. Often these methods are presented as competing forces. In actuality, each is unique, yet they overlap and complement each other.

For its part, the art of family counseling concentrates on the affective side of human interactions. It stresses opening families up to the expression of feelings and helping them, through experiential learning, to overcome fear and resistance. The art of family counseling enables families to gain a different perspective of themselves by enactment and emotion. Its various forms promote the expression of truth about human relationships in nondefensive ways. Through artistic means, families may come to appreciate and incorporate the wisdom of the ages. Family counselors may also share themselves realistically and openly with their client families through artistic means. Common art forms such as music, literature, drawing, and dance/movement give insight into family dynamics, as do more spontaneous creative interactions. In effect, the art of family counseling encourages families and counselors to enliven sessions and change through concentrating on feelings.

The contributions of the science of family counseling are equal to those of art. Science and scientific methods have helped family counseling gain respect and rigor. They have promoted a more uniform language between those in the field and have increased the validity and reliability of family counseling research. Through the scientific method, paradigms have been created, modified, and destroyed (Kuhn, 1970). Science has been behind the evolution and growth of the field of family counseling.

Although differing in many of their foci, art and science are complementary in family counseling. They share the common characteristics of honesty, parsimony, duality, and insight (Burke, 1989). Further, they use the common language of metaphor to communicate ideas between professionals and spur each other to expand and develop new methods and theories. Thus, they help the field of family counseling to grow in the variety of practices it utilizes and in its predictability. For the field of family counseling to continue to be viable, both the art and science that are behind its growth must be maximized and dovetailed in theory and in practice.

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2

Equilibrium: A Conceptual Context for Family Counseling

Peter A. Powers
Charles H. Huber
New Mexico State University

Many individually oriented approaches to counseling and psychotherapy tend to promote practitioners' and particularly therapists in trainings' adoption of a more passive interactional style. Regardless of the particular theoretical approach, family counseling typically requires action and direct executive control of the session on the part of the counselor. Otherwise, family members' norms emerge to take the executive position, conflicts appear and escalate, and neophyte counselors wish they had chosen an occupation in which the levels of emotional intensity were not so great (Thomas, 1992).

Haley's (1969) statement to family counselors on "The Art of Being a Failure" summarized this stance:

> The Five Bs That Guarantee Dynamic Failure:
> Be Passive
> Be Inactive
> Be Reflective
> Be Silent
> Beware (p. 61)

Families initiating family counseling need to recognize that the counselor is in the executive position. To assume this position with confidence, the counselor must have a cognitive map of what constitutes the major goal of family counseling efforts prior to ever engaging a family in treatment (Thomas, 1992).

The most widely utilized and researched concept in the psychological literature relating to optimal human functioning is *adjustment*. Unfortunately, this concept has tended to provide direction for therapeutic interventions that are primarily linear notions of increasing what are assumed to be positive behaviors, feelings, and thoughts (potential), or decreasing what are presumed to be negative behaviors, feelings, and thoughts (pathology). The wide acceptance of this adjustment dichotomy in individually oriented therapeutic thought has biased research and practice, focusing attention somewhat singularly on psychopathology or coping skills and strengths. Equilibrium is herein asserted to be a more pragmatic position for the family counselor.

Adjustment

A plethora of research studies and other writings have defined *adjustment* as either the absence of problems or the presence of strengths and resources. For example, Noonan, Evans, and Hendricks (1988) used seven subscales of the Personal Adjustment and Role Skills Scale completed by caregivers to describe personal adjustment in patients diagnosed with strokes. They hypothesized that personal and family variates frequently associated with stroke outcome might influence aspects of personal adjustment. These authors conceptualized "personal adjustment in disability" by reference to Katz's (1983) definition:

> [F]reedom from psychopathology as manifested in social behavior, performance of community and home responsibilities, and family satisfaction with the patient's condition and activities. Being married or in a nursing home, typical stroke-outcome predictors, had little influence on adjustment patterns and a large amount of variance in adjustment . . . [was] unexplained. (p. 250)

In a similar fashion, Kendall and Fischler (1984) studied 150 families and their 6- to 11-year-old children. They hypothesized that interpersonal cognitive problem-solving skills (ICPSs) are crucial in a child's adjustment: Because a child is incapable of solving interpersonal problems, he or she may fail to perform important personal or interpersonal tasks and experience frustration and low self-esteem. Their results indicated: "Neither ICPS skills, problem-solving behaviors, nor overall problem-solving ability (i.e., reaching a decision) were found to have robust systematic relationships with child adjustment" (p. 889).

It would appear that the position conveyed by the term *adjustment* is limiting. Equilibrium is posited as encompassing more than the dichotomous designations of maladjusted versus adjusted behaviors. Equilibrium subsumes dichotomous descriptors and defines a state wherein the dynamic interaction of pathologies and potentials results in more optimally functioning families and other social systems.

Beyond Either–Or Concepts

To move beyond the dichotomy of either pathology or potential, it is useful to understand how these seemingly opposite descriptors are, in fact, complementary and interactive. The systemic concepts of *recursive complementarity*, *wholeness*, and *feedback* help to expand the family counselor's focus.

Recursive Complementarity

An incomplete picture is drawn through distinctions wherein either potentials are viewed as positives to be increased or pathologies are viewed as negatives to be reduced or eliminated. Distinctions suggest multiple comparisons. Focusing on how something is different from something else ignores the necessary connection between them. For example, stability or persistence cannot be described without reference to change. It is impossible to speak of something being stable without reference to the absence of it changing. Likewise, change must be defined in terms of what or how something is now different from what it was originally—the "stable" way it previously existed (Watzlawick, Weakland, & Fisch, 1974).

Similarly, degrees of cooperation are often incompletely contrasted with degrees of competition:

> When any differentiation is made, two ways of talking about its sides are always present: (1) we may speak of their distinction; or (2) we may speak of their connection . . . consider the distinction between predator and prey. The logic of this relationship is often specified in terms of a predator attempting to catch its prey. On the level of individual foxes and rabbits, for instance, the fox is usually seen as working for a momentary victory. At the level of species interaction, however, the population size of the fox will be curbed by the popula-

> tion size of the rabbits. Each individual victory for a fox may therefore be seen as contributing to what someday will be a loss for the fox population. (Keeney & Ross, 1985, pp. 47–48)

Making distinctions in considering pathology and potential can thus be seen as either a duality of excluding opposites or a recursive complementarity: "Recursive complementarity refers to the higher-order view where the interaction of different sides is underscored . . . the two sides must maintain a difference to interact, while their interaction connects them as a whole system" (Keeney & Ross, 1985, pp. 48–49).

Wholeness

If pathology and potential are viewed as more than exclusive opposites—also interactive components of a greater whole—a more comprehensive both-and or systems view emerges. The systemic concept of *wholeness* focuses on the relationship between the whole and its parts: "To study component parts out of the context of the other parts is not meaningful, for each is different without the other" (Becvar & Becvar, 1982, p. 30). The concept of wholeness includes more than simply adding individual parts of a system together:

> Consider, for example, the sound produced when an orchestra performs. It is not just the individual sound of each instrument that makes the music; rather the instruments combine in a myriad of ways to produce the much richer sound of the entire orchestra. Thus, the whole is different from the sum of its parts. (Huber & Driskill, 1993)

Feedback

One aspect of such rich and diverse interactions between parts and the greater whole is the ability of the parts to actively regulate the whole system, as well as the system regulating the parts. This basic idea involves feedback. Feedback can be positive or negative. Whether it is positive or negative has nothing to do with whether it is good or bad, but rather whether it encourages change from the status quo (positive) or discourages change with the goal of maintaining the status quo (negative). Both positive and negative feedback are necessary components in a functional system. Without change or stability when it is needed, a system will cease to function effectively. Consider a lawnmower motor with its throttle stuck at low speed. The absence of positive feedback or no change when change is needed will result in stalling when attempting to cut high grass. Likewise, without a stable trottle (negative feedback) maintaining the status of the mower motor, it will fluctuate wildly, stalling or racing to a breakdown. It is the dynamic balance of the two forms of feedback that promotes a smooth-running lawnmower and a well-trimmed lawn.

Equilibrium

Recursive complementarity, wholeness, and feedback all posit that the presence of both pathology and potential are needed for optimal functioning. The definition of *equilibrium* provides a position encompassing these three: "a state of balance between opposing forces or actions" (*Webster's*, 1976, p. 386). Equilibrium is a both-and perspective deemphasizing the good or bad of potential or pathology, stating instead that each is helpful in defining the other and both are necessary for optimal functioning. The value of using a both-and, or "polyocular," perspective was described by de Shazer (1985):

> Metaphorically, this process is similar to that of depth perception. The right eye sees things in its way, while simultaneously the left eye sees things differently. The difference between the two eyes' views leads to the bonus of depth perception. Clearly, it is not that the right eye is correct while the left eye is wrong or vice versa. (pp. 19–20)

By continually seeking to consider and promote equilibrium, the both-and of circumstances that confront them, family counselors and those with whom they work gain a bonus: a depth perception that contributes to more successful therapeutic outcomes (Huber & Driskill, 1993).

For example, take family functioning in a family composed of two young children and two working parents. The parents' attempts to ideally care for their children may result in both attending to the needs of the children (potential) and reducing the emotional closeness of the parents as a marital couple (pathology). After a full day at work, completing necessary household tasks, and attending to the varied needs of their children (potential), the couple collapses in exhaustion in bed without even a moment of intimacy—their marital closeness having been sacrificed (pathology). Viewing the reduction of the emotional closeness of the couple resulting from their child care as something bad (pathology), to be separately diagnosed and treated, ignores its developmentally temporal nature as well as the contribution it makes to the overall functioning of the family and, ultimately, to a satisfying marital relationship (potential).

Equilibrium assumes a higher order view, excluding distinctions about good or bad, potential or pathology. Instead, the focus of treatment is on establishing whatever dynamic mix leads to optimal functioning. An excess of pathology can be seen as a signal to the "system" to develop new potentials or utilize existing abilities (as in the decision to get up a few minutes earlier and go the speed limit instead of getting another ticket while rushing to work). A lack of pathology can be seen as an indication that more deviance must be allowed for the good of the overall system (as in the beneficial disruption in daily routines that allows someone time to grieve the loss of a loved one).

For instance, in counseling a grieving family, family members might be directed toward optimal functioning by beginning to view any intrusive thoughts as not only healthy and normal but helpful in processing their feelings of loss so that necessary daily routines might continue. If instead they were encouraged to control their thoughts (e.g., think positively), it is probable that the grieving process might be stalled with future complications likely. Suggesting that family members emote freely could be equally problematic. Denial or exaggeration of family members' thoughts, feelings, or behaviors, although ways of coping with their circumstances in the short term, would likely make the situation worse in the long term because they are competing solutions. Optimal functioning would tend to result from a complementary counseling focus. Such a focus encourages family members to (a) allow thoughts to come to consciousness about the loved one, (b) recognize feelings of loss and sadness, and (c) maintain emotional control in settings where it would disrupt functioning (e.g., on the assembly line or in school) and emoting freely when the setting was appropriate (e.g., at home or with friends after school).

Equilibrium and the Family Counselor

Equilibrium helps clarify one dilemma that many professionals face when transitioning from an individually oriented therapeutic perspective to a family-counseling perspective: that the issue is not whether there are troubled individuals *or* troubled families. Equilibrium posits that there are both: "Where there is one, there is the other" (Huber & Driskill, 1993). Thus, the subsystem of the individual in the family both acts on and is acted upon by the larger family system. If one experiences disequilibrium, so does the other. Equilibrium further asserts the value of a dynamic balance between pathology and potential. This does not mean that the two must be equalized, but simply moderated in relationship to each other, with extreme degrees of either being seen as less functional.

The family counselor becomes a part of the family and yet maintains some separateness from it. Because families typically experience difficulties as a result of rigidly held rules and patterns of interaction, less effective family rules and patterns of interaction must be challenged. Equilibrium offers the family counselor, like a tightrope walker, a position of leverage with the family by constantly shifting his or her emphasis (weight) on the deficits (pathologies) and resources (potentials) of the family system. Thus, the counselor can calibrate sufficient "deviation" in the family system so that it can move toward a more healthy balance between open inquiry and self-protective stability—a state of equilibrium (Huber & Driskill, 1993).

Summary

Slater (1974) asserted that "any pattern, value, ideal, or behavioral tendency is always present at any time, along with its polar opposite. Only the relative emphasis given each pole and the ways of arranging their simultaneous expression tend to change" (pp. 182–183). Family counselors employing equilibrium as their guiding position can more accurately assess and utilize the beneficial and complementary nature of both the pathologies and potentials that family members possess so together they might promote a more optimal level of functioning for all.

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3

Family-of-Origin Work for the Family Counselor

Volker Thomas
Phil Striegel
University of Iowa

Family-of-origin work in general (Kerr & Bowen, 1988), and the construction of their own genograms (McGoldrick & Gerson, 1985), are considered important tools to help mental health professionals make the paradigm shift and personal transition from individual to family counseling. Implications of family-of-origin work for this transition are described on a theoretical level. Then the findings of a qualitative study are discussed in which more than 30 graduate students of a family-counseling class were asked about experiences constructing their own genograms and dealing with their families of origin as part of the process of collecting information for the genogram.

Training Family Counselors

Different family-counseling models teach systems thinking in different ways. For structural and strategic counselors, training involves the use of live supervision and taped sessions to teach specific techniques (Colapinto, 1988; Haley, 1987; Mazza, 1988; Minuchin & Fishman, 1981). Those counselors who employ a Bowen theory model depend a great deal on the use of co-therapy and family-of-origin work to learn how theory is applied in family counseling (Papero, 1988).

Whatever the preferred method of training, the different models of family counseling describe similar qualities of a competent counselor. Nichols (1988) summed up these qualities when he stated that family counselors must be able to "think critically, to weigh the factors observed in a dispassionate manner and reach reasoned conclusions" (p. 116). Minuchin and Fishman (1981) spoke of the importance of knowing technique so well that the counselor is able to act spontaneously with a family. Haley (1987) described the qualities of a good family counselor as having life experiences and the capacity to demonstrate a wide variety of behaviors. Papero (1988) related the importance of differentiation of the counselor. Differentiation is a complex concept and is described as the ability to act intentionally and to be close to others while maintaining separateness.

In each of these models, training of counselors involves the development of the ability to use techniques in interaction with families. Along with this ability to use technique must come a sense of competence—the sense that the counselor can be comfortable working as a differentiated person within the context of the family system. Although it receives varying emphasis in different models, the study of the counselor's family of origin is considered an important tool in this process of development. It is particularly used by proponents of the Bowen's Family-Systems Theory approach (Bowen, 1978, 1980; Friedman, 1991; Kerr, 1981; Kerr & Bowen, 1988; Papero, 1988). Although Haley (1987) clearly stated that he does not believe in family-of-origin work or other personal counseling for training family counselors, and although Minuchin and Fishman (1981) are also not overt supporters of personal counseling, it is our contention and experience that family-of-origin work is equally beneficial in other family-counseling training models as well.

Family-of-Origin Work and Constructing a Genogram

Family-of-origin work in the context of this chapter is defined as any attempt of a counselor to explore and work through emotional issues and interactional patterns pertaining to the family in which the counselor grew up.

Family-of-origin work can take the form of actual family counseling sessions with the counselor's family of origin (Framo, 1992). The main objectives of such sessions—usually conducted as part of the counselor's training—are twofold. First, on a personal level, the family counselor in training is exposed to family sessions and gains experience and insight in the counseling process from a client's perspective. The counselor has the opportunity to work through unresolved relationship issues with immediate family members (i.e., parents, siblings) that otherwise could interfere with the counselor's performance later in his or her career as a family counselor. Psychodynamic family counselors such as Framo (1992), Nichols (1988), and Bowen (Kerr & Bowen, 1988; Papero, 1988) stressed the importance of family-of-origin work as part of the training process. This is to protect family counselors from projecting unresolved family-of-origin issues onto client families, and consequently making inappropriate interventions.

Second, by working on their own family-of-origin issues with their families, counselors in training experientially learn how to conceptualize family-related problems from a systems perspective and to pragmatically experience what basic-systems concepts are all about. For example, working through the discipline methods used in their own family of origin will help counselors understand that there are many possible ways to discipline children. Generally, this process will make them more open and flexible in dealing with a wide variety of presenting problems. Thus, a counselor's family-of-origin therapy experience can provide important tools that significantly enhance the counselor's transition from an individual to a family-systems perspective.

More frequently, family-of-origin work involves the development and explanation of the counselor's genogram. A *genogram* is a format for drawing a family's organizational structure and its relationships over at least three generations (McGoldrick & Gerson, 1985). It was developed primarily out of Bowen's (1978) Family-Systems Theory. Genograms contain a wealth of information, including: (a) names and ages of family members, (b) important dates, (c) family structures, (d) family rules, and (e) multigenerational patterns of family interaction and dysfunction. The genogram helps the counselor in training to see him- or herself in a new way. It enables a counselor to reframe, detoxify, and normalize emotionally laden issues about his or her family by creating a systems perspective (putting things in a different perspective) that helps to track family issues through space and time. The genogram helps the counselor to see the "larger picture" of his or her family, both currently and historically, and forces him or her to shift from a focus on individuals to a focus on relationships. The structural, relational, and functional information about the family on the genogram can be viewed both horizontally across the family context and vertically through the generations (McGoldrick & Gerson, 1985).

The development of a genogram is an extensive process for the counselor and is constantly reexamined as the counselor gains understanding of his or her own family. This makes the genogram an important tool for the counselor to learn about the basics of family structure and processes of interaction. Family counselors can internalize their understanding of basic concepts through this example and transfer that understanding to other family systems. On a conceptual level, the process of constructing a genogram enhances the transition from an individual to a family-systems perspective.

Whatever the model of training, the counselor must develop an ability to make hypotheses about what is happening with the family in the room and make interventions to test those hypotheses. Family counselors will interact with families based on what they know about families. They originally learned about families from their families of origin. They developed ideas about what it means to be a child, a sibling, a male, or a female. Along with these lessons in a particular reality, they internalized certain emotional patterns that only rarely are conscious. Counselors have internalized emotions and beliefs about certain male–female interactions, about child abuse, or about marriage in general.

These internalized emotions and beliefs may appear as reactions to material presented in counseling and can get in the way of doing effective counseling. It is important for the counselor to make intentional interventions, rather than interventions that are based on a reaction to emotional patterns from his or her family of origin (Guerin, Fay, Burden, & Kautto, 1987). For example, a couple trying to decide whether to divorce may be impeded by a counselor who believes that marriages must be saved at any cost according to a rule in his or her family of origin. The emotional reactivity of the counselor may be too subtle for the counselor's awareness, but still powerful enough that the couple may not be heard or feel safe to proceed with counseling. The counselor must be able to act on information that is available in the room and be aware of personal positions that may impede counseling.

The family and the counselor together create a system of interdependent parts. An effective family counselor is able to understand and act within the rules of this system, but still have maneuverability to temporarily move closer to the family, withdraw from it, or join with a particular member. It is necessary that the counselor be able to think in terms of systems and to choose whether to remain outside of the family problem or to join with the family in an intentional way.

The more that a counselor has worked on uncovering the emotional reactivity to his or her family of origin, the more differentiated he or she will be (Bowen, 1980). The counselor will be able to think and act for him- or herself. Working through family-of-origin issues via family-of-origin sessions and/or developing his or her own genogram increases the counselor's level of self-differentiation (Bowen, 1980; Framo, 1992). This not only enhances the transition from an individual to a family-systems perspective, but ultimately becomes an integral part of the transition process on a conceptual and personal level.

In summary, family-of-origin work can be an important tool in the counselor's transition from an individual to a family-systems perspective by helping him or her develop: (a) an internalized understanding of systems thinking with emphasis on examining family relationships in terms of both structure and process; (b) an awareness of personal values and emotional reactivity that may impact on the way that the counselor will interact with families; and (c) a capacity to remain an individual who can act intentionally with families despite highly emotional conditions.

The Genogram Project

The genogram project was conducted in the context of a class assignment for a graduate-level course in marriage and family counseling. The main objective of the course was to introduce graduate students from counseling majors other than marriage and family to family-systems theory and systems-oriented counseling models. Based on the readings by Bowen (1978, 1980; Kerr & Bowen, 1988) and McGoldrick and Gerson (1985), the students were to construct a genogram of their family of origin and then write a paper describing the process of (a) contacting their family members, (b) collecting family data, and (c) constructing their genograms. At the end of the paper, students were asked to write down what they learned from the process in regard to applying family-systems concepts. The project's research question was to find out whether the construction and processing of the genogram as embedded in the course would be an instigator for a paradigm shift from individual to systems thinking, and consequently could be used as a tool to enhance the transition from individual to family counseling in the context of family-counseling training.

Thirty-six students participated in the project. Their majors included: (a) counseling and human development with an emphasis on school counseling ($N = 11$), (b) rehabilitation counseling

($N = 6$), (c) substance abuse counseling ($N = 10$), (d) social work ($N = 4$), (e) counseling psychology ($N = 2$), (f) clinical psychology ($N = 2$), and (g) school psychology ($N = 1$). All students were in programs that emphasized an individual perspective of counseling. Thus, constructing and processing a genogram was considered as an indicator of whether and how the participants had made some kind of transition from an individual to a family-systems perspective.

A content analysis was conducted of the 36 genograms and process papers. The following themes were identified.

1. *"Learning About Myself in the Context of My Family."* For most students, it was crucial to define themselves in the context of their families. They rediscovered themselves as part of something larger. As one student put it, doing the genogram "was as if I were putting together a jig-saw puzzle and the jig-saw puzzle was 'me' and 'my family.' This multigenerational study proved to be valid for me in discovering my own reality as part of my family reality." The reality of self was defined as part of a larger reality: the family.

2. *"Visualizing Oneself as Part of a Larger Picture."* "Constructing this genogram was a positive experience for me. I was so happy when I got done that I just left it out and looked at it for a while. It still amazes me, as simple as my family is, how complex my extended family is." This student's experience was shared by many others. Visualizing oneself as part of the larger family picture introduced a new way of looking at oneself and defining oneself from a different perspective.

3. *"Importance of Family for Personal Growth."* Another aspect of this *larger picture* metaphor was mentioned by several students in regard to the family's influence on their personal growth. "Constructing this genogram reminded me of how important my family really is to me, and it has shown me that I will not discover anything new if I don't look for it." This student made a direct connection between the importance of her family as derived from the genogram and the potential for discovering new things as a direct consequence of the learning process while dealing with her family of origin.

4. *"Learning About Family Members and Relationships."* One student summarized this theme very bluntly and powerfully: "My first discovery was that I had relatives." This basic discovery implies a major shift in perspective—from internal and introverted to a relational and extroverted definition of self. Another aspect of this theme included the redefinition of relationships as described by one student. "Seeing my grandfather's humble tears talking about his family made me feel that I had been introduced to a person after having known the man for so long." Reconnecting with relatives

and redefining relationships in order to overcome projective processes that are based on childhood introjects (Framo, 1992) appears to be a crucial process for family counselors when making the transition from individual to family counseling. Another student summarized this theme in regard to getting to know family members on a different level. "I had never seen my mom react so excitedly to a school project before. This made me realize how important a sense of family is to her—something I had not known about. To me, that is what these genograms are best used for. They open up relationships and give us the opportunity to explore and get to know other family members; not just the obvious, but really get into what they are like as people."

5. *"Reviving Family Relationships."* Rekindling relationships with family members was another theme identified by many participants. The structure the genogram provides is a nonthreatening, safe, and unique opportunity for students/counselors to approach family members and revive relationships without immediately falling back into old family patterns, which may lead to discomfort and defensiveness on the part of one or more family members. The following quotations may illustrate the theme: "The genogram gave me the excuse to visit with my grandparents"; "During the process of talking with my dad about our family, I felt some bonding with my dad and a closeness I haven't experienced with him for several years"; "I enjoyed doing this project if only for the reason that it forced me to sit and talk to my parents without any brothers, sisters, or anyone else interrupting. I honestly can't remember the last time that happened."

6. *"Discovering Family Patterns."* The theme of discovering family patterns was probably the most powerful of all. Realizing that family members interacted with and related to each other in somewhat predictable ways across generations was a real eye opener for most students on a personal and conceptual level. "While I was looking at the genogram and thinking about my relatives a clearer and clearer picture emerged out of the fog of my family which I had never seen before." Identifying family patterns was exciting as well as scary for many students, as one admitted: "If I had known what I was going to uncover, I don't know whether I would have done this assignment. However, looking at my family now, I'm glad to know what I know." Another participant summarized his project as follows: "I am never going to look at my family the same way again as I did before constructing this genogram. When I talk to clients in the future I probably want to do a genogram and see what their families are like."

As these six themes indicate, two metathemes emerged that appeared clearly related to a paradigm shift that had taken place on the participants' conceptual and personal levels. Themes 1, 2, and 3 reflected aspects of the "larger picture" in which participants saw themselves when working on their genograms. This metaphor can be interpreted as an attempt to conceptualize oneself from a systems perspective not only on a cognitive level but also on an emotional level. Visualizing themselves as part of a family system helped students/counselors to begin the transitional process of shifting their perspectives of how to define presenting problems in the counseling situation from an individual to a systems perspective.

Themes 4, 5, and 6 showed how the parts of the larger picture related. Participants reported how they learned about relationships among their family members (themselves included), how they revived some of these relationships, and what interactional patterns they discovered. This metatheme of "relationships" reflected the second step in the shift of perspectives from individual to systems. Students/counselors not only discovered the larger picture as the first step, but also experienced and recognized how the parts of this picture interrelated and interacted. They included themselves in the picture, which enabled them to identify relational patterns both on a cognitive (learning about relationships and discovering family patterns) and emotional level (learning about and reviving family relationships).

In summary, the results of the presented project describe two important steps of the paradigm shift from an individual to a systems perspective for counselors: (a) to view oneself as part of a family system, and (b) to discover and conceptualize family relationships and interactional patterns from a systems perspective. Both are important and necessary steps in the transition from individual to family counseling.

Conclusion

This chapter presented family-of-origin work of counselors and the construction of their genograms as a bridge from an individual to a family-systems perspective. On the basis of the conceptual paradigm shift from individual to systems thinking, and in the context of family-counseling training, family-of-origin work was described as a useful tool to enhance a counselor's transition from individual to family counseling.

It was argued that, during the transition process, family-of-origin work impacts a counselor on two levels simultaneously. On a conceptual level, a counselor directly learns how to apply a systems perspective of family counseling. On a personal/emotional level, a counselor gains direct access to his or her own family-of-origin issues and is encouraged to work through them. This process is necessary to widen the counselor's emotional horizon, which helps him or her deal with an extended range of presenting problems.

The themes as identified in the genogram project confirmed the notion that genogram work supports the shift from an individual to a family-systems perspective. Its emotional impact was limited because the project did not include participants' personal family-of-origin counseling.

Overall, the argument was strongly supported that family-of-origin work and genogram construction are excellent methods to introduce family-systems thinking and to enhance and ease the transition from individual to family counseling.

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PART II

THE CLIENTS

4

Cultivating the Language of Play: The Young Child in Family Counseling

C. Wayne Jones
Philadelphia Child Guidance Center

Young children introduce considerable emotional intensity and behavioral unpredictability into their relationship systems. Although this is often a challenge for their families, in a therapeutic context this is a resource that can create tremendous opportunities for change and growth, both at an individual-personal level and at the family-system level. Additional resources brought to the change process by young children include: (a) the capacity for greater flexibility and openness, (b) a strong preference for focusing on the here and now, and (c) a bias toward affective engagement (Keith, 1986; Whitaker, 1982). Play brings these resources to life. The primary purpose of this chapter is to describe informal play-based strategies that capitalize on these resources in family counseling with young children. Particular emphasis is given to how these interventions can simultaneously affect both individual-child and family-level processes.

Unfortunately, the natural resources of young children too often remain untapped in current therapeutic practice. In part, this is because parents and children are likely to be separated during treatment. Surprisingly, this is true even when the counselor subscribes to the systemic notion that children are best understood and treated within the context of their families. Surveys suggest that less than one third of family counselors include children of any age in their sessions (Greenwood, 1984; Korner & Brown, 1990). Even when young children are invited to attend family sessions, counselors often exclude them from meaningful participation by listening and talking primarily to the parents; the children are left to play alone as passive observers. Such an arrangement creates a treatment context where the individual strengths and emotional needs of the young children can too easily be overlooked or neglected.

Prior to the advent of systems thinking, parents and children were even more likely to be separated during treatment. Here, the reverse problem was manifested. A play expert would treat the child individually while parents were either excluded, seen in adjunctive therapy sessions, or given parenting advice. In traditional play therapies, the idea was for the child to have a reparative or growth experience primarily with the therapist (Axline, 1976). In this arrangement, the emotional needs of the individual child became foreground, and the unique strengths and emotional needs of the parents or larger family system receded to the background where they were likely to be overlooked or neglected.

Young children and their families are not served well by either of these clinical practices. Increasingly, family counselors (e.g., Chasin, 1989; Combrinck-Graham, 1986; Guerney & Guerney, 1987; Levant & Haffey, 1981; Wachtel, 1987; Zilbach, 1986; Zilversmit, 1990) are recognizing this problem and calling for the development of clinical practices that include young children within family counseling in a meaningful manner. One unifying idea found in many developmentally based approaches (Greenspan, 1992) and in many family-systems approaches (Minuchin, 1974) is a nonpathological, process orientation. There is the belief that young children and their families are highly active agents in their own learning and development, and that, regardless of situational success or failure, the general goal of behavior is mastery and adaptation. Therefore, with the goal of promoting the socioemotional development of the child, as well as that of the parents and larger system, counselors should strive to create a therapeutic context that encourages all family members to actively engage in or experiment with new ideas and ways of relating.

Key ingredients for creating such a therapeutic context can be found in play—the natural language of young children. Lawrence Frank (Hartley, Frank, & Goldenson, 1952) noted that "to read the language of play is to read the minds and hearts of children" (p. viii). However, this language is not always read so easily by grownups, much less spoken with any degree of fluency. In contrast to adult languages, the symbols utilized in play are imprecise and meanings are constantly changing, informed primarily by emotional experiences of the moment. For example, a 2½-year-old girl growled as she voraciously ate her popcorn. When asked about it, she indicated she was eating one of her most feared insects, the bumble bee. The next day, she threw the popcorn, pretending it was a box full of balloons. She became very indignant with her father when he assumed she was still conquering bees.

Although play is purposeful and logical in nature, the child creates both the symbol and its meaning. There are rules and structure, but they are fluid and nonbinding. When children can woo others to join them in a dialogue within this language, a context emerges that is filled with novelty and freedom to experiment with new behavioral possibilities. Herein lies the tremendous power of play for communicating and transforming both individual experience and interpersonal relationships. Perhaps this is what Winnicott (1971) meant when he stated that "psychotherapy is play" (p. 38). This notion was elaborated on and applied to the practice of family counseling by Keith and Whitaker (1981).

Although this concept is a useful one for working with children of all ages in family counseling, the play-based interventions described in this chapter focus primarily on preschoolers (2½–5 years). By this developmental period, children have established some symbolic abilities and the capacity to modulate moderate levels of internal and external stimulation. Although children in this age range may be quite facile with verbal language, they are just learning to apply symbolic logic in the navigation of socioemotional challenges. It is extremely important that family counselors have an accurate grasp of the child's developmental abilities and match interventions to them. For a more detailed discussion of the phases of socioemotional development and its assessment in early childhood, please see Jones and Rostain (in press) or Greenspan (1992).

The Tools of Play

Young children know within the first 25 seconds of entering a room where family counseling is to be conducted whether they are truly welcome. This assessment is very straightforward. If interesting, developmentally appropriate toys and furniture are clearly visible, children know that the owners of the space are likely to appreciate and understand young children. If the room is barren of toys, stocked only with formal adult-size chairs and objects, counselors are going to have a much more difficult time convincing children that they are child friendly. The presence of breakable, delicate equipment or artwork that is within easy reach of the child may make the context even more restrictive and unfriendly because both the therapist and the parents then have considerable stake in preventing the child from acting like a child and being curious (Chasin & White, 1989).

Although anything in the counselor's office could conceivably become imbued with symbolic value and temporarily transformed into a toy, there are some materials that lend themselves more readily than others for therapeutic play. Above all, the materials included in the family-counseling office should be nondistracting, allow for easy collaboration with adults, and engender a sense of physical and psychological safety both for the children and the parents (Chasin & White, 1989). The toys also should be neutral enough to allow for a wide variety of creative, imaginative play themes. Toys that suggest or invite violence or acting out, like toy guns, knives, and war toys, although not harmful, are unnecessary. Young children do not need such concrete theme-specific toys to experiment with feelings of anger, aggression, and hostility (Donovan & McIntyre, 1990). This occurs naturally with more theme-neutral material, such as toy people, cars, furniture, animals, monsters, or baby dolls. When combined with play settings, such as a sandbox or a dollhouse, a rich variety of symbolic play themes are possible. Expressive toys such as building blocks, clay, and paper and crayons are also useful.

Play as a Moderator of Child Misbehavior

Having a counseling room well stocked with the tools of play is essential when trying to understand the meaning of a young child's in-session behavior, particularly disruptive behavior such as temper tantrums, whining, and frequent interruptions. Given the normal emotional lability of young children, particularly those with more spirited temperaments (Kurcinka, 1991), and the pressure on therapists to identify meaningful interactional patterns within a limited amount of time, the opportunity for overinterpretation of negative behavior is enormous. When the counseling office is inadequately equipped with toys and the primary mode of interaction is verbal, the most straightforward, least pathology-oriented hypothesis to consider first would be simple boredom.

Generally, young children do not cope well with boring, toyless environments. In fact, the more imaginative and adaptive the young child, the more likely he or she is to generate personal excitement by utilizing the few raw materials available, namely the adults in the room. When either the counselor or the parents misinterpret in-session negative behavior as a parent–child control issue, and the behavior is, in fact, a child-room problem, a power struggle can develop. This may prematurely focus the unwitting family counselor on the executive functioning of the parents and prevent a more fine-tuned exploration of the developmental needs and strengths of the child. Furthermore, a power-oriented intervention would be iatrogenic if it reinforces a dysfunctional family pattern in which children's emotional behavior is chronically overinterpreted.

Even within more enriched counseling offices, however, family counselors may unwittingly encourage power struggles between parents and their young children. This is particularly likely when children's efforts to moderate their anxiety are confused with control issues. For example, during one highly emotionally charged family counseling session, in which two parents were arguing about the nature of their relationship, their 5-year-old daughter screamed for the mother to join her in a building-blocks project. With the idea of helping the parents draw more effective boundaries with their daughter, a much needed skill, the counselor insisted that the parents first finish their discussion. Unfortunately, both the counselor and the parents had misjudged the level of tension in the room and how frightened the girl had become. The girl's mildly annoying and demanding behavior quickly escalated into a full-blown tantrum, including wild throwing of the blocks, kicking, and screaming.

In the previous example, neither the counselor nor the parents noticed the earlier clues provided by the girl indicating that she needed support in moderating her anxiety beyond that which play could provide. Her play had deteriorated from highly organized, focused play themes to a series of more fragmented, aggressive play moments. By paying closer attention to subtle changes in the tone or content of children's play during a family-counseling session, counselors can intervene in a more timely and supportive manner. Here the counselor could have requested the parents to engage their daughter in a dialogue about whether the conversation was scaring her and then provide reassurance. This intervention would promote leadership roles of the parents around nurturance issues as well as provide a more constructive way to interpret their daughter's negative behavior. For the girl, this intervention would confirm her emotional experience, and she would be encouraged to label and verbalize her feelings. This would bring her greater proximity and support from her parents, something much needed at this point in her development.

The coping resources of young children are often not well developed, leaving them more vulnerable for misunderstanding or distorting interpersonal experiences in terms of their own fantasies. Generally, the opportunity to retreat into play during a family-counseling session provides young children with a powerful method for moderating their anxiety (Bergel, Gass, & Zilbach, 1968; Scharff, 1989). By giving some direction to and monitoring the play, the counselor has an effective tool for adjusting the degree to which the child is exposed directly to emotionally charged material. In this way, having appropriate play materials available increases the sense of psychological safety for the child. This is why it sometimes appears that children actually listen better when playing than when doing nothing other than sitting and talking.

Kaslow and Racusin (1990) suggested rethinking a family-counseling format when adult-supported play is not sufficient to calm an anxious or overaroused child, and the conjoint family sessions appear to exacerbate symptoms. They recommended individual counseling for young children who evidence serious behavioral and cognitive disorganization. However, before assuming that these more severely symptomatic children who are developmentally off course cannot be treated in a family context, it is recommended that counselors first assess the degree to which the parents can provide a safer emotional environment in the counseling office. Kaslow and Racusin strongly cautioned against conjoint sessions when the caregivers do not seem to care about the child or the caregivers have little capacity for reflecting on their child's thoughts and feelings.

Play and Multilevel Hypothesizing

There are three major errors that family counselors commonly make in hypothesizing about the presenting problems of young children and their families. One, whereas family process is tracked very closely, little time is spent getting to know the unique behavioral style and emotional capacities of the young child. Two, whereas counselors track individual child processes in depth, they spend little time getting to know the unique personal stresses and strains confronted by the parents within an inter-generational context. Both of these paths can lead to the oversimplified notion that young children are simply passive cogs in some larger, creaky, systemic machine.

The work of Thomas, Chess, and Birch (1968), Brazelton and Cramer (1990), Stern (1985), and numerous other developmental researchers make it clear that babies do not simply wait for their development to unfold or to be influenced by parents. In fact, they enter the world prewired with certain sensitivities to experience—ready to both initiate and actively participate in the construction of their relational worlds. Therefore, clinical hypothesizing must be multilevel. That is, hypotheses must be informed by understanding the specific vulnerabilities and coping resources of the child, the parents, and the larger family system in which they are embedded.

A third potential error is to underestimate the number and power of normative developmental challenges confronted by young children and their families. Early childhood is a time of rapid change, full of frightening, strange new demands that can severely challenge the competent parent and the otherwise healthy, loved, and secure child (Jones & Rostain, in press). As William James (cited in Frank, 1976) described the task confronting the young child, "it is a great blooming confusion, which the child has to organize by putting into it some orderliness and meaning, some way of making situations and events more understandable" (p. 73). The task confronting parents can be quite similar. This is the stuff of growth and mastery, and the reason play is so critical in this process.

The Preschooler Who Was Afraid to Play: A Case Example

A child's spontaneous play, along with family interactions in response to the play, can provide important clues regarding: (a) the specific nature of emotional challenges with which the child and family are struggling, (b) the strengths and vulnerabilities the child and parents bring to the emotional challenges, and (c) the specific pattern of family interactions that constrains mastery efforts. For example, Sean, a 4-year-old boy, was seen in family counseling following dismissal from his neighborhood preschool due to chronic inattentive and disruptive behavior. His parents indicated he was also experiencing numerous unusual fears at home, such as fear of his bedroom air conditioner, keyholes, and cracks in the walls.

Sean's unique strengths and vulnerabilities were revealed as much by what was not observed as what was clearly seen. Within the initial session, Sean's spontaneous play resembled that of a much younger child. This highly verbal, energetic, friendly, and inquisitive youngster impulsively jumped from one toy in the room to another, showing little purposeful, thematic play. His brief attempt to engage with a dollhouse and toy figures abruptly ended after stacking everything into piles. His emotional range appeared severely limited. All interactions were reduced to giggling silliness; meaningful two-way social exchanges were absent. Although Sean's spontaneous drawings showed well-developed fine-motor skills, they consisted primarily of detailed electrical circuits or geometrical designs.

Sean's nonimaginative, primitive play skills and social immaturity were not attributable to cognitive deficits because psychological testing suggested a full scale IQ of 148. Nor was it possible to explain Sean's behavior as temporary regression in the face of overwhelming family tension, given its chronicity and consistency across social contexts, such as the school and neighborhood. An individual-level hypothesis posited that Sean is a bright youngster with a spirited temperament whose socioemotional development is clearly off course. That is, he does not yet have the socioemotional capacities necessary to deal with the normative challenges typically facing 4-year-olds. Family-level interventions alone may reduce the intensity of the presenting symptoms, but would be unlikely to provide the specific skills Sean needs to move back on developmental track.

Greenspan (1981, 1992) provided a clinically useful, integrated model for understanding the major developmental tasks or challenges that children must master before progressing to more complex, adaptive ways of communicating and relating. Within this framework, Sean has yet to learn how to translate to the world of emotions and relationships the skills he has developed for symbolically representing and navigating through the physical world. This capacity normally is emerging by 30 months. By 4, children are usually able to connect complex emotional ideas into "emotional thinking," which entails applying logic and reasoning to feelings and relationships.

Children who have not yet mastered this challenge, like Sean, are at high risk for behavioral problems (Greenspan, 1981). In part, this is because they have difficulty reading their own and others' intentions accurately. They often have trouble understanding the differences between thoughts and facts, impulses and actions, or intentions and outcomes.

Generally, children develop this capacity through ongoing parent–child interactions that allow for a two-way dialogue and experimentation with different ideas and feelings. Object-relations theorists (e.g., Scharff, 1989; Winnicott, 1971) describe interpersonal contexts that engender feelings of psychological safety as "holding environments." There were few, if any, of these exchanges observed during the early sessions with Sean. When the mother, a straight-talking, high-energy, emotionally expressive woman, attempted to play with her son, she tended to become very directive and controlling with regard to the symbolic meaning the play materials would have. When Sean resisted her efforts, she responded with helplessness and disappointment. The father, a quiet, but very serious and logical man, remained interested but peripheral throughout these family play efforts. When his wife ran into conflict with Sean, he became somewhat paternalistic and provided her with a very analytical, logical suggestion, which implied criticism of her emotionality.

The relational structure that emerged during play seemed to mirror ongoing, day-to-day family patterns. No one in this family seemed comfortable with the world of emotional ideas and play. Instead, there was an atmosphere of fear and dread, as if the family could become overwhelmed and driven into chaos if anyone gave in too much to their own internal experience. This may explain the high degree of boundary intrusions present in the family's interactions with one another. This emotional environment would be sufficient to constrain the parents' ability to facilitate the development of their son's representational capacity because sustained and meaningful curiosity about one another's emotional experience has become too threatening.

A relational-based developmental history provided a clue as to the origin of the family's fears. During Sean's toddler years, the mother's last remaining parent, her father, was dying with a chronic illness and she was his sole caregiver. She became extremely depressed. With little provocation, she often found herself screaming and crying uncontrollably; sometimes this became rage and was accompanied by the throwing of household objects. Sean's father became consumed in his efforts to calm his wife's out-of-control emotions. When this failed, he distanced from both his wife and son. Despite their best intentions, neither parent could be reassuring or emotionally available to Sean during this period of chronic family stress and strain.

Unfortunately, this is a developmental period for young children when experimentation with anger and aggression and a push for increasing autonomy is the norm. To successfully master or incorporate these emotions into a more organized sense of self, it is critical for the young child to experience such uncomfortable emotions as temporary and tamable. As a toddler, Sean's testing of the limits perturbed the already fragile family emotional system beyond a tolerable level, leaving him the target of his mother's rage and isolated from his father. These experiences terrified Sean of his own anger, which he understandably came to identify as dangerous alien forces coming in through cracks in the wall. The parents were equally frightened of these powerful emotions. A positive outcome for this child and family will be the increased capacity for experiencing, communicating, and coping with these difficult emotions. This clinical theme unites both individual child-level and family-level goals.

Informal Play-Based Interventions

Family counseling with young children requires counselors to move back and forth comfortably between the more reality-bound language of the adult world and the more metaphorical language of young children (Ariel, Carel, & Tyano, 1985; Keith & Whitaker, 1981). This requires contexts in which the child's play is a significant part of the ongoing therapeutic process, but not necessarily the dominant focus of all transactions. This is contrasted with traditional individual play therapy (e.g., Axline, 1976), in which the relationship between the child and play materials is the exclusive focus. This use of play is termed *formal* due to its explicit, prescribed focus on the inner life of the child. The term *informal* is employed to describe the therapeutic uses of casual, spontaneous play that is primarily aimed at shifting the child's relationship to the family and vice versa. Although both forms of play-based interventions are useful, the latter lends itself most readily to working with young children within the context of family counseling.

For example, a 30-year-old recovering addict recently began a family session by declaring that she had successfully passed the 1-year mark of sobriety. While the counselor engaged the mother in a conversation about how she had accomplished such a challenging feat, her 4-year-old son wandered aimlessly about the room with toy cups and saucers. The boy had experienced considerable neglect while his mother had been using drugs, yet, due to the tendency of treatment programs to focus exclusively on the addict, he found himself still isolated and unable to participate in his mother's life.

An informal play-based strategy at this moment in the counseling might involve lightly and humorously chastising the mother for not inviting her son to this celebration. The idea would be to engage the mother in a more nurturing, supportive relationship with her son. Afterall, the boy has the most at stake in her recovery. The counselor could symbolically help the boy and mother negotiate a place in one another's lives by joining them in setting the table and serving pretend coffee and cake.

Informal play-based strategies most closely resemble the well-known structural family-counseling technique known as "enactment." This is a here-and-now, process-oriented technique that is designed to capture and transform problem-maintaining family interactions as they are unfolding within the session (Colapinto, 1991; Minuchin & Fishman, 1981). Unfortunately, this technique has become overidentified with the exploitation of young children in the service of empowering parents' executive skills than with the facilitation of emotional development. However, the idea that informs this technique is a sound one (i.e., that change is more likely to occur when family members actively engage with one another, immersing themselves within the emotional struggle related to a problem, rather than simply talking about it in the abstract). The counselor has a highly active role within the structural model, monitoring and supporting the unfolding transactions until they become stagnant or off course. During an enactment, the counselor may choose to (a) refocus family members, (b) highlight stumbling blocks and successes, or (c) inject new ideas.

As with an enactment, counselors often need to be directive when using play in family sessions, yet leave sufficient room for spontaneity (Chasin, 1989). This may be as basic as setting the stage for a certain emotional or interactional theme by selecting the types of play materials that are brought out of the toy closet in a given session. For example, an abundant number of warm and furry stuffed animals or baby dolls may be the play materials of choice when the intent is to encourage parents and their young children to engage with one another around nurturant themes. On the other hand, planting a few toy monsters among the play materials may be quite useful in normalizing and desensitizing the expression of frightening emotional themes among constricted families.

Chasin (1989) noted that being directive may mean (a) deciding when play will occur, (b) providing a general structure for the play, or (c) directing who will join in and who will observe. The level of structure or support that is provided should fit the child and family's behavioral style or emotional needs at a particular moment in time. In general, the more extreme the family's behavioral style is, the more structure or support will be required to create a sense of psychological safety. The transactions of impulsive, reactive families can easily deteriorate into chaos when therapists are too nondirective with play. On the other hand, more constricted, anxious families may freeze in the face of so much freedom and the accompanying noise, messiness, or regression such freedom brings.

Wachtel (1987) described two gentle, counselor-directed, informal play-based interventions that can be useful across a wide variety of family behavioral styles. One involves telling children stories that capture the forbidden feelings, unspoken fears, and unconscious concerns shared by key family members. The stories expose and normalize taboo feelings while giving the child and other family members permission to feel them. By enlisting the parents in the storytelling, the counselor can indirectly provide a rationale and a method for them to work on their own issues. A related informal play-based intervention described by Wachtel involves "playing baby" to help parents and their children accept and incorporate their disowned dependency needs. It is important that parents initiate and structure the game so that negative behavior is not inadvertently reinforced and the child is not shamed.

The Anorectic Preschooler: A Case Example

The following case example highlights one way in which a young child's casual, spontaneous play during a family session can be utilized to reframe an individual problem as a relational one and catalyze movement toward more healthy, constructive family transactions. Two highly successful professionals with three young children presented for family counseling due to their concern for Molly, their 3½-year-old daughter. Molly had been diagnosed as failure to thrive; she often refused to eat, and had shown no weight gain over the last 12 months. Although Molly had cystic fibrosis, a chronic illness that affects the way food is metabolized, neither her parents nor her physicians believed this accounted for the problem.

Driven by a very real fear of potential loss, the parents had become locked into a self-defeating power struggle with one another and with Molly. The family was so consumed by their sense of urgency about basic survival issues that nothing was left over to feed their emotional hunger. Family interactions were marked by hypervigilance and defensiveness—a context in which neither play nor collaboration were possible.

One of Molly's assets was her rich imaginative skills. Early in the family counseling, she was observed to be playing in the sandbox with a large set of zoo animals. She merrily sang to herself as she intently worked to individually walk each animal across the high, treacherous embankment that surrounded the sandbox. She indicated that they were on their way to a celebration known as the "animal fair." Unfortunately, one of the smaller animals fell off the embankment, behind the desk on which it sat, making locating the animal very difficult. The parents noticed the girl's pain. Before the parents had time to minimize the girl's suffering with false reassurances or offering to buy another one, they were encouraged to join her in an expedition to find the lost, frightened animal.

The mother liked the idea, but voiced considerable anxiety about not knowing what to do. She and her husband were supported by suggesting that they simply show curiosity about what their daughter was doing. They were told to let their daughter direct them because she knew more than any of us about the secrets of play. When overly reactive parents have permission to be quiet and "not do anything," they sometimes begin to identify important clues about how to approach their child in a manner that better matches his or her behavioral style or temperament (Greenspan & Greenspan, 1989). However, for adults who are accustomed to continual motion and social centrality, such as Molly's parents, this seemingly passive role may feel like a huge challenge.

This anxiety was quickly overcome when the parents noticed how Molly brightened and quickly took charge of the play, directing them on where to look and what needed to be moved. When it looked as if one parent was about to give up and pull back from the play, the other parent was encouraged to invite him or her back. They eventually discovered the lost animal and were able to celebrate their success together. Molly liked the experience so much that, throughout the rest of the session, she purposefully knocked an occasional animal to the floor, furtively looking up and smiling teasingly at her parents.

The idea was to (a) support the parents' efforts to collaborate as a team within the play, (b) block the parents' tendency to distance from painful emotional themes, and (c) facilitate an experience of success in helping their daughter within an arena that did not involve instrumental tasks, such as eating. Molly was able to (a) experience being in control of her parents in a legitimate arena, (b) symbolically experiment with risk taking, and (c) obtain practice with a wider range of emotional experiences. Most importantly, both the parents and their daughter were able to engage with one another in a pleasurable activity for a more sustained amount of time than anyone could remember over the last year. This brief informal play experience enabled the parents to make a connection between the symptom and family relationships, moving the counseling in a very rich and productive direction. By the conclusion of this session, everyone concurred that what Molly needed most was a more balanced and nourishing emotional diet, which included feeding her more of themselves, through play.

Conclusions

Play is essential for both successful family functioning and healthy child development. It is what allows parents to meaningfully connect with their children and their children with them. However, many families with young children who present for family counseling are either awkward or unskilled with the language of play. Therefore, it is critical for family counselors to be as facile with the metaphorical language of childhood as they are with the more reality-bound language of the adult world. In a way, the family counselor who works with young children needs to be bilingual, maintaining the flexibility of thought and action to bridge the language gap between children and their families on demand. More often than not, the problem that keeps young children separated from their families within their homes, as well as in treatment, may well be a language barrier.

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Mexican-American Families and Acculturation: Implications for Family Counseling

Sylvia Soto-Fulp
Robert L. DelCampo
Diana S. DelCampo
New Mexico State University

Traditional Mexican-American families share, with other ethnic family subcultures in America, the challenge of acculturation as they confront mainstream American traditions and values. Although many families make the transition smoothly, some Mexican-American families find a conflict between their traditions and mainstream American family norms. This chapter provides an overview of normative and psychosomatic family systems and compares these families to the traditional Mexican-American family system. Its purpose is to show the similarities and differences among traditional Mexican-American families as normative or psychosomatic. In doing this, it is hoped that counselors will be better able to determine if problems related to acculturation are normative as the Mexican-American family transcends from one value system to another, or if the family consequently displays symptoms of a psychosomatic family.

Normative Versus Psychosomatic Family Systems

The normative family is a homeostatic system. It regulates, maintains, and changes itself as circumstances warrant (Minuchin, Rosman, & Baker, 1978). The family system, consisting of various subsystems (e.g., mother–father, parent–child, brother–sister), functions to equip its members with a "self-hood" or identity that fosters both a sense of belonging (i.e., cohesiveness) and a sense of being separate from the family system.

Flexible rules develop that guide interactions, allowing families to change as circumstances change. Boundaries between individuals and subsystems emerge that define who participates in a given subsystem and how they participate. For example, the arrival of children signals the need for new boundaries to be established between parental, sibling, and extended-family subsystems. These subsystems become differentiated enough to allow freedom while simultaneously preventing excess interference by other subsystems. The spousal subsystem establishes a boundary that allows the child access to both parents while excluding him or her from spousal functions. This executive hierarchy allows parents to have a higher level of authority than children. The normative family adapts and restructures as the children mature and progress through a series of predictable developmental stages. Parents develop flexible, rational, and authoritative functioning relative to their children's developmental stages. Rules allow for and encourage extrafamilial involvement. As a result, the normative family develops boundaries that allow flexible communication in and out of the system (Minuchin et al., 1978).

In contrast to normative families, psychosomatic families have been characterized by five main interaction patterns:

1. Enmeshment: extreme intensity in family interactions, resulting in a lack of privacy and family members' intruding on each other's thoughts and feelings.
2. Overprotectiveness: a hypersensitivity to family members' welfare. This can affect the children's development of autonomy, competence, interests, and activities outside the family.
3. Rigidity: an overcommitment to maintaining the status quo. Issues that threaten change in the system are not explored.
4. Lack of conflict resolution: denial of the existence of problems and the inability to confront differences in order to negotiate resolution.
5. Involvement of the child in parental conflict: psychosomatic families are more likely to have a child who acts as a mediator in parental disputes (Minuchin et al., 1978).

Often psychosomatic family systems develop rigid boundaries around themselves and diffuse boundaries surrounding members of the family. When the extended-family system is included in family interaction, this inclusion may take the form of an unhealthy coalition of a relative and a family member against other family members. For example, a husband's mother may join with her son in a coalition against his wife over an issue such as childrearing practices. Conflict between spouses may lead to an overinvolvement of one parent with a child and the child's subsequent disengagement with the other parent. The parent's overinvolvement with the child is both a result of and a cause of emotional distance from the spouse. When a spouse turns to a child to fill closeness needs, the other spouse may distance him- or herself because of feeling neglected.

Whereas normative families modify their structure to accommodate changing circumstances, psychosomatic families tend to increase the rigidity of a structure that is no longer functional. For example, rigidity often takes the form of treating adolescents in the same manner as when they were younger and had different developmental needs. Although independence in adolescents is considered appropriate in normative families, enmeshed psychosomatic families tend to see this independence as rejection and betrayal. Parents may gain control by inducing guilt in children and reframing overinvolvement as love and protection. Children and parents begin to feel a burden of responsibility for each other's emotional well-being. Rigid rules that discourage extrafamilial peer involvements contribute to the child's immaturity and difficulty in joining peer groups. This cycle of family overinvolvement continues, further escalating the family rigidity.

Family rules against open expression and conflict resolution lead to a symptom that represents a passive rebellion of a person who cannot rebel more directly against overprotective, intrusive parents. If the adolescent in an enmeshed, overprotective system sees parents as overly intrusive and overly controlling, this sense of powerlessness may lead to a symptom that only the adolescent can control and manipulate. This is the case with an anorexic teen. He or she alone controls what, when, and how much he or she eats or exercises.

Some Characteristics of Traditional Mexican-American Families

Mexican-American families have traditionally organized themselves around an extended-kin network (Mindel, 1980; Ramirez, 1980). Father, mother, and children often live with, or in close proximity to, a wide array of aunts, uncles, cousins, and grandparents. Others from outside the family may be "adopted" as God-parents and God-children during religious rights of baptism, confirmation, and marriage. These *compadres* or *comadres* then are also considered part of the extended-kin network (Keefe, Padilla, & Carlos, 1986). Family values tend to stress family interdependence. Cohesiveness predominates, and a strong sense of nurturance, affiliation, and cooperation is valued. Self-sacrifice in the interest of love and family unity is promoted (Ho, 1987; Levine & Padilla, 1980).

In the traditional Mexican-American family, a strong executive hierarchy is commonly adopted by the parental subsystem (Diaz-Guerrero, 1975). Gender and age type casting may result in older males being given more respect, power, and authority. The father is often considered the family head, or *Jefe de la case*, with the oldest male taking over in his absence. Although the father has a strong instrumental role, the mother also shares in the executive hierarchy through the expressive role. She often has just as much or more actual power in decision making and family functioning as the father. Yet the father is, at least figuratively, the family head.

Marianismo is the term for the female counterpart of what has typically been called *machismo* in males. It refers to the responsibilities and power of the female in the executive hierarchy. The traditional nonassimilated Mexican-American family generally holds rigid male and female gender roles and defines the female role as nurturer, life giver, and self-sacrificer. The wife rules through the power of love, whereas the male role requires the husband to be protective of females and an authoritarian. The parent–child subsystem is often given greater importance than the husband–wife subsystem. There may be a rigid boundary surrounding the extended-family system and relatively diffuse boundaries surrounding individual subsystems within the extended family. Individuals are encouraged to turn to their extended family first for all kinds of aid, including emotional, financial, and practical needs. In particular, females are encouraged to remain close to each other. Mother–daughter or sister-sister ties are lifelong and do not necessarily diminish following marriage. Siblings are also encouraged to take responsibility for each other. As a result, children, especially daughters, may be overprotected because brothers, older sisters, aunts, cousins, and so on "look after" them in the same manner as parents would. The conflict between traditional Mexican-American families and the American nuclear-family system can lead to difficulties in acculturation.

Acculturation Problems of Mexican-American Families

The traditional Mexican-American family, with its emphasis on cohesiveness through extendedness, may be particularly vulnerable to acculturation difficulties during its assimilation into mainstream America. In the following case studies, four acculturation problems are illustrated: (a) loss of extended-kin support, (b) clash of traditional values with American values, (c) difference in rates of acculturation, and (d) changes in intergenerational relationships.

Loss of Extended-Kin Support

When the family separates from its extended-kin network, significant changes in the way it meets its instrumental and expressive functions occur (Sluzki, 1979). This is illustrated in the case of Lupe:

> Lupe came to counseling when she became severely depressed in association with a conflict with her youngest daughter. She stated that she had become despondent with suicidal ideation when she discovered her youngest daughter was abusing drugs and engaging in lesbian activities. Her youngest daughter, age 18, refused to enter treatment for drug abuse. An older daughter, age 20, had previously been treated for bulimia, along with depression at age 17. Lupe stated she had failed as a mother and cited her daughters' problems as reasons for her failure. She also felt emotionally abandoned by her husband. She felt that she had dedicated herself to care for him and their two daughters while he had become absorbed in his work, recreational activities, and occasionally drinking with his friends after work.
>
> Lupe expressed long-standing feelings of loneliness and depression. She stated that things began to get worse approximately 10 years ago, when she decided to invite four of her nieces to move to a city close to her from the interior of Mexico. She stated that she had done this to relieve the feelings of being cut off from her family of origin in Mexico, and to encourage her daughters to bond with their aunts (her nieces). Instead the daughters reported feeling angry at their mother, who exhausted herself caring for her nuclear family as well as attending to her extended family on a daily basis. Lupe reported doing this in an effort to recreate a sense of family that she had enjoyed as an adolescent. She spoke of her having enjoyed a "best friends" relationship with her mother and sisters before her mother's death and before she moved from the interior of Mexico. She expressed disillusionment by her daughters' refusal to bond with their aunts, and was unable to relate to their permissive, disrespectful ways.

When her nuclear family relocated, Lupe found herself isolated from her extended family. She began to have problems. In desperation, she moved her extended family to a city in closer proximity to her so she could have more regular interaction with them. This was her attempt to meet expressive needs for bonding. Family counseling focused on restructuring the family by strengthening the spousal subsystem and reframing the daughters' attempts to balance family loyalty and interdependence with their growing needs for autonomy and independence.

The process of acculturating into mainstream American values often stresses a traditional Mexican-American family beyond its normal ability to cope (Falicov, 1988; Jalali, 1988). In America, the isolated nuclear family is normative. As Mexican-Americans move toward this norm, both parents and children may feel an inordinate sense of responsibility for each other, particularly with meeting each other's emotional needs for closeness. Previously, both parents and children could turn to extended family, siblings, parents, or compadres to meet companionship needs. Rules defining who comprises the "family" included many members outside the nuclear family to whom one could turn for emotional and practical support. The rules that were functional within the extended-kin network (e.g., "Always look to family first") change as Mexican-American families move toward the isolated nuclear-family norm, which may deprive family members of extrafamilial involvement. This can lead to problems because family members may feel disloyal for "going outside the family" for support, or it can lead to enmeshment if the nuclear family remains within itself in meeting these needs.

Clash of Traditional Values with American Values

The adaptive function of cohesiveness can evolve into a form of enmeshment for more traditional members of nuclear Mexican-American families. Diffuse boundaries surround individual family members within the nuclear family, and rigid boundaries isolate the family from mainstream America. This puts the family at increased risk for developing into a psychosomatic family. Differences in traditional Mexican-American versus American values hinder parents' readiness to loosen direct control and supervision of children as they mature. The second case describes Suzie, an adolescent whose mother brought her to counseling due to complaints of rebelliousness.

> Fourteen-year-old Suzie was brought to counseling following admission to the hospital emergency room. She had attempted to commit suicide. Suzie was born during her mother's first marriage. Her four younger siblings were the products of a second marriage. Most of Suzie's large extended family lived in Mexico. Her mother reported having divorced Suzie's father when Suzie was 1 year old, because she discovered that her husband was having an affair. Her mother remarried 2 years following the divorce.
>
> Suzie's mother was the only family member to attend family sessions. In the sessions, the mother wept openly while discussing her

> daughter's obsession with her appearance. She complained of Suzie's tendency to seek out and attempt to please her friends and ignore her family's need for closeness. Mother also attempted to focus on various acts of self-sacrifice she had made for Suzie. She complained of Suzie's ingratitude and the destructive influence she believed Suzie's peers were having on her. She felt that Suzie was becoming increasingly obstinate, disrespectful of her elders, and rejecting of her family that loved her the most. She also related that, from time to time, she would send Suzie to live with relatives in Mexico to remove her from seductive, dangerous outside influences. Mother would bring her home when she felt Suzie needed her direct supervision. Mother grieved the sense of loss of the significant relationship with Suzie, compared with her own feelings of closeness to her mother and sisters who still lived in Mexico. She also complained of a feeling of alienation from her spouse, whom she described as a detached workaholic.
>
> As Suzie's stay in the hospital continued, her mother demanded to withdraw Suzie from the hospital prematurely when she discovered she had earned unit privileges. These privileges allowed her to exchange reward tokens for fingernail polish and other feminine toiletries. She stated that the hospital was corrupting Suzie because she had not yet made her *quincieñera* (her 15th birthday announcing her as a young lady).

In this case, treatment revolved around an acculturation issue of traditional values versus more liberal American values. It involved separating what appeared to be overinvolvement of the mother–child subsystem and strengthening an apparently disengaged marital subsystem hierarchy. To address the wife's feelings of isolation from her husband, marital therapy could begin to clear up the overly diffuse boundary between mother and child. The father's involvement in Suzie's treatment was thus necessary and crucial in appropriately restructuring the family.

Suzie's mother's demands to prematurely remove Suzie from the hospital came because she felt that her family values were being compromised by the hospital program. Parents often react with exaggerated restrictions and discipline when children assimilate into mainstream America at a faster rate than the parents do. This seems to be the case with Suzie's mother. American culture is often perceived as alien, threatening, and hostile to traditional family and moral values by these parents. In turn, children may react to the increased parental control and concern with anger, guilt, and rebellion in the formation of symptoms that allows them some degree of power or control (Minuchin et al., 1978).

Difference in Rates of Acculturation

Conflict may also strain family relations when one spouse assimilates American values at a faster rate than the other. Examples would be when economic constraints force the wife to enter the workforce and become exposed to more liberal ideas of gender roles and expectations, or when either the husband or the wife's career goals create a disparity in levels of formal education and assimilation of new ideas. These changes often leave the other spouse feeling estranged, increasingly enmeshed with the children, and longing to return to the locale of the extended family, due to the need for support and validation. As an example, consider the case of Ricardo and Maria.

> Ricardo, age 28, and Maria, age 26, have a young daughter named Rosa, age 1. When Ricardo wanted to relocate and take a job 5 hours away from their families of origin, Maria was somewhat hesitant to go. However, she believed that it was in the best interest of their nuclear family for Ricardo to get this "good" job as an assistant manager in a chain restaurant, so they moved.
>
> Ricardo was an excellent worker and was very successful in this job. Within the year, he was promoted to manage a restaurant in a neighboring city that was still more than 4 hours from where their families lived. During the time of these two jobs, Ricardo put in many long hours, mostly working the "graveyard shift" at the restaurant. To improve the income of the family, Maria also took a job and hired child care for Rosa. Family interaction was very poor. Maria would get home from work at 5:30 p.m. Ricardo would leave at 6:00 p.m. to begin his night-shift hours. Ricardo would return home at 8:00 in the morning, which was one-half hour after Maria had left for work. Ricardo also was working 6 days a week. Maria would find herself alone with her daughter when Rosa was not with a baby-sitter. The family relationships were disintegrating. Ricardo and Maria worked, and Maria additionally took on the responsibility of caring for the baby. Although they were beginning to accumulate a good savings, their quality of life was quite strained. Maria continually asked Ricardo to quit and find another, more suitable job. He refused, stating that this was the best money he could earn for the family.
>
> After several months, Maria became so frustrated that she quit her job, left Ricardo, moved back with her family of origin, and found a job to support herself and her daughter. Ricardo had a difficult time understanding this. He was very proud that they were amassing a considerable amount of money that he thought would benefit the family.
>
> When Maria remained adamant about not moving back to the city in which Ricardo worked, he reluctantly transferred restaurants to another one in the chain that was closer to where Maria, Rosa, and their extended families lived. He gave up his manager's job and took another assistant manager's job. This, too, was night-shift work. Ricardo and Maria found more of the same: Ricardo would come

> home from work just as Maria was leaving, and vice versa in the evening.
>
> When Ricardo and Maria entered family counseling, it was apparent that the baby was very attached to her mother, yet distant from Ricardo. Maria presented the ultimatum that if Ricardo did not quit his job immediately and spend more time with the family she was going to seek a divorce. Ricardo complained that he was only trying to provide for his family, and he certainly did not feel comfortable quitting a job before he had a better one to which to move.

When one spouse acculturates at a faster rate than another, conflict results. Thus, family counseling focused on improving the mutual decision making in the spousal subsystem. This case exemplifies a common response of Mexican-American families to isolated nuclear-family stress: a return to the extended family for support and nurturance. This was evidenced by Maria when she moved back to her parents' home.

Change in Intergenerational Relationships

Tendencies toward acculturation difficulties when the family is cut off from its extended network also occur when the family maintains the traditional value of giving increased importance to the parent–child dyad over the wife–husband dyad. A traditional Mexican-American female has often learned to fulfill her self-esteem needs by maintaining an identity involving her ability to function primarily as a nurturing mother. Her role as nurturing wife and separate individual may be far lower on her list of priorities. Within an extended-kin network, she would likely remain close and involved with her children, grandchildren, and other relatives. However, with a more independent separation of children from the family of origin, the normal transitional family phase of reconnecting with a spouse following the launching of young adults is more difficult for spouses who have seen themselves as parents primarily and spouses secondarily. Parents may find themselves demanding the same amount of loyalty and respect from their children that they gave to their own parents. Mothers may feel that the cultural expectation that their daughters grow up to become the mothers' best friends (as they did with their own mothers) no longer seems attainable. This disappointment in what was formerly considered to be a reasonable expectation in an extended-kin network may move the family toward reactions containing elements of psychosomatic family functioning. This idea is elucidated in the case of Josie and Magdalana.

> Josie and her daughter, Magdalana, age 15, came for family counseling because Magdalana was truant from school, staying out late most

> evening, and failing most of her subjects in her freshman year of high school. Josie complained that Magdalana had no respect for her, and would much prefer to spend time with her friends than at home with her or the rest of the extended family.
>
> During sessions, it was discovered that Josie had been divorced and remarried when Magdalana was about 2 years old. Although Magdalana had lived with her stepfather for 13 years, she had neither bonded with him nor perceived him as a parental figure. Whenever disagreements or disciplinary issues would come up between Magdalana and her stepfather, Josie would always intercede in favor of Magdalana. The quality of the relationships in the family had gotten bad; Josie reported that her husband had questioned her as to whether she wanted to remain married to him or to divorce and live only with Magdalana. Josie described how she was really hurt by this question, but that she would always choose her daughter over her husband. Josie was hoping that family counseling would help to strengthen the mother–daughter relationship between she and Magdalana. However, her interpretation of the mother–daughter relationship was one of a traditional Mexican family relationship, where Magdalana would have unquestioning respect for Josie. Magdalana did not see her relationship with her mother in the same way.

Family counseling focused on the mother–daughter dyad and making that boundary less diffuse by exploring and changing existing family rules. No work was done with the spousal dyad because the father and mother had separated.

The normal transitional stage that most families face as children mature, develop increased independence, and leave home may become even more challenging for acculturating first- and second-generation Mexican-American parents. Traditionally, children do not move away from their parents physically or emotionally. Parents have often relied on their children's English language skills in managing transactions and serving as intermediaries with the Anglo culture. This tendency to depend on the children causes adjustment problems for parents as the children mature and move out of the family of orientation. It can also disrupt the hierarchical structure that maintains a greater degree of power within the parental subsystem while the children are still at home.

Parents may feel a loss of self-esteem and confusion over the adolescents' struggles for autonomy, and they may misinterpret their behaviors as rebellion. Older children may have greater reluctance for adhering to rules set by parents whom they consider to be out of touch with the realities of the society. This contributes to an exaggerated generational gap between parents and children. The children come to expect increased amounts of independence and autonomy. The root of the problem is that Mexican-American parents have been taught to perceive these autonomous behaviors as disloyal and disrespectful to traditional family values. A parent who grew up in a home where his or her own parents were never questioned or confronted may perceive the children's self-assertive behavior as disobedient and disrespectful of parental authority. As a result, parents often react with increased authoritarianism and control. In turn, children respond with attempts to assert even more independence, which leads to more control by the parents, and so on.

Implications for Family Counseling

The Mexican-American family's tendency to turn to an extended-kin network for aid and comfort is generally considered to have an adaptive function within the extended-kin network (Vega, 1990). Markides, Boldt, and Ray (1986) cited a much lower incidence of psychiatric treatment of Mexican Americans as compared with other groups. This may be largely due to the strong family support system that protects and nurtures the individual. Ramirez (1980) found a positive relationship between the extent and size of the extended-kin group a person has available and the person's mental health status. He also found that the larger and geographically closer the extended family is, the better a person's mental health status.

However, the challenge for family counselors is to be able to distinguish between normative cultural cohesiveness and pathological enmeshment emanating from acculturation. Working effectively with Mexican-American families requires one to develop a judgment and sensitivity so as to avoid overreaction to normal closeness in the family system. Emphasis on family loyalty in a large-kin network has been effective for generations in Mexican-American families. However, this emphasis may create strain for a young couple whose primary task is the establishment of clear boundaries around the spousal subsystems (Bell, 1985). Family loyalty, when limited to the nuclear family, may be overly taxing to individuals who previously were able to turn to many relatives for support. Now they may perceive themselves or other family members as disloyal when they seek support outside the extended family. They may attempt to compensate by being overly restrictive, which creates increased tension and conflict.

Traditional Mexican-American cultural processes are normal and adaptive within the context of the Mexican-American culture. However, these processes can lead to increased conflict and dysfunction as the family assimilates into mainstream American culture. The sudden need to accommodate to an isolated nuclear-family system from an extended-family system can be problematic. This is due to the family being detached from its usual extended support and surrounded by unfamiliar customs and traditions that are threatening to traditional Mexican family values. When less acculturated Mexican-American families come to family counseling, they may come with unique needs different from mainstream Americans due to the extendedness of the family system. These needs must be recognized and considered by the counselor if family counseling is to be efficient and successful.

For this population, (a) resolving conflict by restructuring the boundaries between family members, (b) strengthening the spousal subsystem, (c) addressing the issues of traditional values, (d) improving family decision making, and (e) changing family rules are useful. However, family counselors must always consider the cultural context and the rate of acculturation when working with these families.

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6

Community as Family: The Multiple-Family Contexts of Gay and Lesbian Clients

Darryl Dahlheimer
Jennifer Feigal
Private Practice, Minneapolis, Minnesota

Community serves a different, and more central, function for gay and lesbian people than for heterosexual people. This chapter focuses on the family functions of the gay and lesbian community (or communities) and the transition into family-systems counseling with this population.

Over the past three decades, the contribution of family-systems theorists has been to contextualize clients' emotions and behavior, rather than diagnose individual pathology or focus on personality as the key to intervention. The challenge with gay and lesbian clients, whether individuals, same-sex couples, families of origin, or gay and lesbian parents with children, is to expand the counselor's range of context to the level of community, which can be "family of choice," and the key intervention level.

The Failure of Families of Origin in Nurturing Their Gay/Lesbian Children

Most families of origin are not able to complete the essential family functions for their gay or lesbian children. Grandparents,

parents, siblings, and even the gay or lesbian children themselves are rooted in the larger culture that possesses a great deal of heterosexism and homophobia, which in turn pound at healthy child and adolescent development.

This climate of heterosexism, in which all children are assumed to be heterosexual, leaves parents ill prepared for the tasks of nurturing a gay or lesbian child. They are unfamiliar with the specific developmental tasks of managing same-sex attractions, unfamiliar with healthy sources of gay or lesbian socialization, and often unwilling to allow their children any exploration of sexual feelings other than "normal" heterosexual ones. With beliefs shaped by the invisibility and stereotyping of homosexuality in the media, parents often replicate the climate of shame, secrecy, and invisibility that is found in the hostile larger culture. There is much unintentional, but real, damage done to the self-worth and security of a gay or lesbian child when the family does not know it has a child with special needs.

Homophobia, the irrational fear and hatred of same-sex-oriented people, creates further barriers to families' ability to nurture those of their children with an emerging gay or lesbian identity (Pharr, 1988). Hatred and fear create reactions of disgust, shock, and betrayal in parents, siblings, and extended family when the gay or lesbian person discloses his or her sexual orientation. This "coming out of the closet" sends shock waves into the family relationships, and families attempt to restabilize through a range of homeostatic responses. One of these responses is to cut off the gay or lesbian child; another is to deny the information in a wish to protect the child from the painful realities of being gay or lesbian in this culture: (a) the violence of "queerbashers" or (b) possible loss of career, residence, friends, or of one's own children in custody battles.

Even minority-group parents, who have skills in teaching their children how to cope with oppression (e.g., racism), often lack willingness or ability to empower their child to deal with dual oppression: minority group status *and* sexual-orientation difference.

Nevertheless, there is still a wide range of potential family responses, and it is important for family counselors to help gay and lesbian clients assess their own families' situations in the most informed manner possible (Strommen, 1989).

Family Member Reactions to Disclosure of Gay/Lesbian Identity

Looking through the lens of a stage model of the grief process (Kubler-Ross, 1969), four types of family adaptations can be identified that parallel the stages of adaptation to loss: (a) denial and bargaining, (b) anger, (c) depression, and (d) acceptance and hope.

Denial and Bargaining

One group of families gets stuck in the confusion of denial. These parents buy into myths that sexual orientation is a choice, an illness that can be cured, or a rebellious phase that will go away if not "reinforced." They bargain with themselves and with their child through (a) pleas to not act on same-sex desires, (b) help from clergy and mental health fringe elements offering cures, (c) prayer for their child's salvation from this sin, and (d) punitive restrictions on liberty so no more "bad elements" can twist their child. Tragically, they cannot affirm or support their child during a time when he or she has a great need for reassurance of belonging, lovability, and integrating sexual orientation as a part of identity (rather than being defined solely by it).

Anger

Other families never move through the grieving process into the "gains" end of the spectrum, and so remain permanently hostile and stuck in anger. These parents experience their child's orientation as a personal and total rejection of themselves, and respond in kind. Responses such as disinheritance, refusal to mention the gay or lesbian child's name ever again, and even physical assault are among the stories of gay and lesbian children who came out to their families only to lose them.

Depression

A third group of families comes to accept the fact that their child is not heterosexual, but get stuck in depression about the meaning of this. At best, they offer well-intended, naive advice about safety, such as the parents who assure their gay child: "Well, just don't tell anyone." Or they genuinely try to be supportive, but simply lack the life experience to be helpful in the skills of managing a gay or lesbian identity, such as dealing with name calling, threats, or discrimination in housing, or the pain of daily invisibility at card stores, at office parties, in books, and at movies. At worst, they anguish about their child's certain unhappiness in a gay or lesbian lifestyle and reproach their spouses and selves for not socializing their child more actively heterosexual, in belief that they might have caused their child's orientation.

Acceptance and Hope

A final set of families finds in their love and commitment to their child the ability to transcend cultural proscriptions and come to a place of genuine acceptance and hope. These parents come to see their child's disclosure as an act of courage and integrity, which often stimulates their own growth spurt as broader persons. Often, they have meticulously unlearned myths by wide reading and exposure to gay and lesbian people, and become an articulate and righteous force for activism—lobbying legislatures for gay and lesbian civil rights, marching in parades under banners proclaiming "I'm proud of all my children," and affiliating with others in groups such as Parents and Friends of Lesbians and Gays (PFLAG). Although these families are a tiny minority, they often act as "psychological foster parents" to the abandoned gay or lesbian children just by their public presence in the community.

It is also possible to conceive of this range of family responses as a developmental continuum of acceptance (Griffin, Wirth, & Wirth, 1986), rather than as discreet stages. But it is important to remember that many families of origin do not make the entire journey, or only certain family members may do so. Relatively few grandparents, parents, or siblings choose the deep commitment required to (a) confront internal homophobia; (b) stand up in advocacy for these children and risk public stigma; and (c) experience the level of fear, shame, and hatred directed at their children for being gay or lesbian in this culture.

The Gay and Lesbian Community as "Family of Choice"

The gay and lesbian community provides an alternative, or replacement, family to fulfill developmental functions when a gay or lesbian person's biological family and society are unwilling or unable. In addition, the community plays an important role as supplemental family in cases where the biological families are supportive of their children, but lack expertise to fulfill their functions for the special needs of gay and lesbian persons.

This section examines five areas of human development where the gay and lesbian community serves as family in response to the failure of both families of origin and societal institutions in meeting the needs of their gay and lesbian children. These five "family" functions are to: (a) directly protect its children from harm or danger, (b) teach its children how to socialize appropriately in the culture, (c) promote self-esteem and a sense of value and worth in its children, (d) help its children develop a sense of identity (roots and specialness); and (e) teach survival skills to cope in the larger world.

Protection

In recent years, there has been open debate in U.S. society about civil rights for gay and lesbian people. At the same time, there has been an increase in hate-crime violence, open firings in the military, and a presidential statement that gay and lesbian families could never be really normal. Additionally, a history of police harassment, blackmail threats of exposure, and low rates of conviction in the courts for assaults and murders of gays and lesbians are all systemic messages that tell gay and lesbian people not to rely on, but to fear, institutions that were set up to "protect and serve."

The gay and lesbian community has provided protection functions through safety in numbers. The 1969 Stonewall Riots in New York City were a direct response to routine police harassment, and served to mobilize a new liberation movement throughout the United States. Similarly, when the federal Department of Health and Human Services refused to publish its own study, which had found that one in three adolescent suicides were gay related, the community led a proactive education effort by organizing three quarters of a million people in a march in Washington, DC, in 1987. On a smaller scale, public marches and projects, such as the "Bashers Get Caught" campaign developed in several cities, regularly occur in response to homophobic events. Finally, advocacy groups such as the Lesbian Mothers' Rights Project provide expertise for parents whose custody rights are threatened because of their sexual orientation.

Socialization

Every person needs to learn socialization skills for successfully relating to other people, groups, and institutions in the larger culture. However, gay and lesbian people are in a parallel position to other minority group members in that they also need bicultural skills (i.e., knowing how to interact both within the minority culture and within the hostile mainstream culture). Learning to interact within the minority culture may be the harder task because most gay and lesbian people have learned to "pass" as heterosexual, thereby avoiding sanctions imposed on openly gay persons in the mainstream culture (e.g., everyone in the choir is gay, but they decide to remain "The Men's Choir" rather than "The Gay Men's Choir" in order to guarantee funding).

Another complication of learning to relate with other minority members in this case is that all gay and lesbian people were raised with models and prescriptions for heterosexual-based interactions. The male–female sex roles that might be complementary for heterosexual intimacy often create dilemmas for gay and lesbian relationships. For example, a double dose of male socialization may mean that gay couples struggle with being overly competitive, sexualizing all intimacy, and being unwilling to be vulnerable. Gay and lesbian people need to learn new ways to undo stereotypes and gendered rules in order to build couples and friendships with other gays and lesbians.

The gay and lesbian community (a) publishes books and newspapers, (b) hosts workshops and groups that help teach what works, (c) provides support for practice, and (d) acts as a reservoir of successful adaptations. Gay- and lesbian-identified counselors in particular serve an "elder" role in teaching coping strategies (e.g., one colleague teaches the slogan, "Don't come out to your family until you have somewhere else to go for Thanksgiving," to clients to illustrate the timing of disclosure vis-à-vis finding community resources).

Because strategies of "passing as straight" always come at the cost of identity wholeness, gay and lesbian people need to develop further skills in self-disclosure and managing homophobic responses. Finding others or starting groups can be difficult because of the risk of exposure (e.g., adding one's name to a mailing list or being seen to associate in the identified community take on dangerous overtones when one's hostile ex-spouse uses it in a custody battle or calls one's employer). The gay and lesbian community offers niches, at varying levels of public exposure, where individuals can explore feelings and belonging with others who are peers. Despite the risks, groups and organizations appear, creating opportunities to practice relationships, explore identify, and challenge oppression in the mainstream culture.

In major urban areas, the community has developed beyond the bars, support groups, and bookstores characteristic of smaller towns into a diverse patchwork of socialization outlets: dozens of gay or lesbian religious groups, newspapers and radio shows, choruses and bands, youth groups, contra dances, potlucks, and sports teams, to name a sampling. This greater diversity of community in turn fosters greater diversity in individuals' own meaning of their gay and lesbian identities, and it creates opportunities for further challenge of stereotypes.

Self-Esteem

Developing a sense of value and worth is an especially important family function of the community because invisibility and hatred permeate the self-concept of most gay and lesbian children. For example, in elementary schools throughout the United States, children learn to say *fag* as a generic, feared insult, and many recesses see children playing a game they call "Smear the Queer" (tackling and piling on a chosen child, usually a gender-nonconforming one). As a result, most gay and lesbian people begin "a quart low" on self-worth, having been raised in, and inadvertantly absorbed, a toxic environment.

The gay and lesbian community provides visible role models and coping skills to move past the assigned shameful identity. Celebratory songs with messages such as "I'm a woman-loving woman" or "Darling, I'm glad that you're gay," archives of famous gay and lesbian leaders, artists, sports figures, and whole neighborhoods of friendly others reinforce the sense that "we are everywhere" and decrease the power of negative stereotypes. Further, the community has developed tools for esteem repair, such as the "camp" humor style that turns stereotypes on their heads. An example of this tool in action occurred at the 1987 civil disobedience at the U.S. Supreme Court: When police responded by donning plastic gloves before moving in to disperse the crowd (as if to dramatize the fear of "infection"), protesters began a chant of "Your gloves don't match your shoes," which helped restore humor and dignity to the crowd by playing with an old stereotype of gay men as fashion obsessed and effeminate.

Sense of Identity

It is a rare heterosexual family that will claim its past gay or lesbian members, most of whom appear in disguise in geneologies as spinster aunts, bachelor farmers, or someone single but living a lifetime with their "best friend." Knowing that there were gay and lesbian people in all times and places of the past, as well as hidden in one's own family history, allows people to normalize their identities and have a sense of roots and pride associated with group identity.

Community helps break down the sense of isolation that most gay and lesbian people intensely experience as they initially discover and name their sexual orientation; it also transforms self-concept from a nonheterosexual, deviant identity into a positive one woven into history. Access to gay and lesbian history means regaining lost heroes and understandings. For example, uncovering the sacred spiritual role of Native-American gay and lesbian people as those "with two spirits" allows current Native-American gays and lesbians to identify possible roles as leaders in cultural transformation, toward a richer social fabric that values diversity and expands definitions of family, friendship, and sexuality.

Survival Skills

Learning survival skills can involve the capacities for judgment, experience, and risk taking to successfully meet challenges and dangers. It could be argued that the realities of racism, sexual abuse, and violence in families and in mainstream U.S. culture mean that all families must now teach their children survival skills. Nevertheless, this section focuses on the additional skills required for coping as a gay or lesbian person in the culture of homophobia that currently exists. It is dangerous to come out and affirm one's identity (i.e., become a target), and it is dangerous not to (i.e., agree to corrosive negation of self). Gay and lesbian children need to be taught not to internalize homophobic realities, yet also to know when, where, and how to stand up for change—what battles to fight and what is a lost cause or unacceptable risk.

One obvious parallel here is racism's impact on minority children's needs. Minority parents have had to teach bicultural skills (this is how one acts at home vs. this is how one has to be in the majority culture). This works because minority parents draw on their own life experiences of having been protectively parented and having interacted with racism in daily life. However, for gay and lesbian people, heterosexual parents lack the experience to pass on, in the same way that White adoptive parents may not know how to prepare their Black child for the invisibility, name calling, threats, stereotypes, and discrimination he or she will face. In fact, White adoptive parents who wish to be successful in this key area need to expose their child to healthy role models and interactions in the Black community as well. Few heterosexual parents choose to promote gay and lesbian awareness among their children despite the probability that one in every five families has a gay or lesbian child (Dahlheimer & Feigal, 1991).

The gay and lesbian community teaches survival skills by establishing information networks (e.g., AIDS-prevention volunteer hotlines) and community forums (e.g., public debates on the role of alcoholism or pornography in the community) that address issues that the mainstream institutions have ignored or used to pathologize gays and lesbians. In addition, creative and symbolic acts of rebellion are made safe in the community context and encourage skills of discernment and assertion. A poignant example of this is the groups of gay and lesbian public school teachers who speak out at Gay/Lesbian Pride marches (which occur in most major cities each June) while wearing paper bags over their heads, both to symbolize their invisible status in the schools and to protect them from summary dismissal, should they be identified by reactive parents who believe myths of "recruitment by homosexuals."

Family-Systems Counseling with Gay and Lesbian Clients

The development of family-systems counseling has opened doors for mental health professionals to contextualize clients' problems and intervene at levels other than one to one with families, groups, social networks, and even subcommunities. Nevertheless, most training and funding for services in the mental health field continues to emphasize an individual focus both in diagnosis and treatment.

Clinicians who wish to be effective with gay and lesbian clients will need to understand the enormously debilitating and pervasive isolation that accompanies the discovery and integration (both by the gay or lesbian client themselves, and by their family) of a same-sex orientation, and respond in ways that answer the contextual dilemmas of problems that gay and lesbian clients bring to counseling. As demonstrated earlier, the essential focus for this population is at the community level because community provides the alternative (replacement) and supplemental (adjunct) roles in fulfilling the core functions of family for gay and lesbian clients. Three key roles await the professional helper who is willing to work systemically.

First, counselors must develop expert knowledge of the gay and lesbian community in order to assist client networking. All gay and lesbian clients struggle with some level of internalized homophobia that creates barriers to exploration. Informed counselors provide direct referral to gay and lesbian community helplines and suggest wide varieties of support and social groups and specific targeted groups. For example, knowing about gay or lesbian AA groups is essential referral for alcoholics who cannot open up in generic AA meetings; gay and lesbian faith groups such as Dignity (Catholic) or Friends for Lesbian and Gay Concerns (Quaker) are uniquely able to help clients resolve deeply felt conflicts between their spirituality and their sexuality; and referring a distraught gay or lesbian clergy, teen, or person of color to a specific group of peers often is that person's best opportunity to normalize his or her feelings and develop hope that someone else really understands him or her.

Case Example 1

John, a closeted gay 40-year-old state legislator who is married and has two sons, seeks counseling for anxiety attacks. Exploration of his feelings revealed terror at losing his career if exposed, and shame about his double life. Key interventions at the community level opened new choices for John. The counselor contracted with him to anonymously call, then attend, a support group for gay fathers; he later found and attended a conference of gay and lesbian elected officials. As a result of the validation and networking he experienced, he talked with his family about his situation and later held a press conference to come out publicly, with acceptable results. In addition to helping this client greatly reduce his anxiety, the therapist avoided becoming stuck on the individual level of endlessly exploring feelings about being trapped in isolation and homophobic limits.

A second area for counselor impact is community assessment and networking. Counselors are often well ahead of gay and lesbian clients in access to resources for developing needed services, and have professional and institutional power that can be translated into new programs and grant proposals. An example of this is outreach programs to gay and lesbian adolescents that are happening through funding aimed at AIDS prevention and education.

Case Example 2

Mary and Susan are a lesbian couple who are raising Mary's two children from her previous marriage. The oldest boy, Frank, has been increasingly angry and uncooperative at home and school, and the family is coming for counseling. In talking with the couple alone, the counselor learned that Susan, as co-parent, was the target of most of Frank's anger, and in return she was the most fed up and ready to uncouple. Mary felt torn in her loyalties to her partner and children, and angry at feeling she was being forced to choose. Frank appeared confused about his mother's relationship and angry at his mother for the divorce. The key intervention in this case was to develop a new resource: a multifamily counseling group for gay- or lesbian-headed blended families. This family met with three similar families in a 12-week multifamily group, which included time in subgroups for children, parents, and co-parents. All four family members felt validated in their subgroups and became able to discuss the secrets and feelings with their family in the large group. Most important of all, they were able to accept, for the first time, the counselor's validation that "you *are* a family" because of the modeling of others.

Finally, counselors must assist their gay and lesbian clients in removing internalized homophobia when there is resistance to exploring resources in the gay and lesbian community. People who are newly "out" and fearful of the unknown, as well as clients who express strong ongoing internalized homophobia (e.g., negative, despairing, and/or stereotypical attitudes toward other gay or lesbian people and groups), need counselors to explore these feelings of fear and shame and to intervene by challenging the client through modeling a convincing, positive attitude toward gay and lesbian people and through contracting with them to challenge old beliefs through exploration of new resources.

Case Example 3

Martin is a 60-year-old gay man who is seeking help for depression on the advice of his physician. Several years ago, he lost his parish and his career as a minister when he came out to his superiors. He has had a series of short-term sexually focused relationships with men whom he met at local gay bars, has two close gay friends, and maintains a friendship with his ex-wife and children. A primary source of depressed feelings for Martin is the hopelessness he feels about ever having a gay partner who can be intimate and a peer. His hopes were particularly dashed when he attended a support group for gay ex-clergy and felt judged and unwelcomed by the men he met. The key interventions in this case were for the counselor to balance the client's ventilation of discouraged and antigay feelings with a confident, optimistic attitude (e.g., validating how well the client, and the vast majority of other gay men, had done despite homophobic oppression), and for the counselor to confront the client's negative beliefs through assignments to continue exploring. A breakthrough occurred when this client met "a nice man" at a social group for gay elders at the community center.

Summary

Family counselors working with gay and lesbian clients must be willing to: (a) diagnose and treat clients' problems in a framework that appreciates special gay/lesbian developmental needs and the failure of families of origin and societal institutions in meeting these needs; (b) understand the concept of "family of choice" and the role of the gay and lesbian community in meeting these needs; and (c) creatively intervene through knowledgeable referral, community networking efforts, and removal of internalized homophobic beliefs that lead to isolation.

As author Rita Mae Brown has suggested to lesbian and gay readers, "We'd better all hang together or we'll surely hang separately" (Brown, 1975, 227).

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Family Counseling Without the Family: Working with an Individual Client

Patricia G. Driskill
Independent School District, Abernathy, Texas

When asked to describe the difference between family counseling and individual counseling, the first thought might be that the family counselor works with more than one individual, whereas the individual counselor does not. However, if family counseling is accepted as a theoretical point of view, it is not guided by the number of clients seen at one time. It is possible to practice family counseling with an individual client, just as some counselors might actually practice individual counseling with an entire family present. Family counseling must be thought of as a lens through which the counselor views clients and their concerns; this orientation dictates the focus of treatment, regardless of the number of persons seen.

All counselors maintain a certain perspective on the counseling process, and this perspective is guided by a theory of helping. The theory may be very explicit and comprehensive, or it may be more general. But at its essence, each theory represents guidelines that direct the counselor's thinking and actions. Family counseling is not just a collection of new techniques, but rather offers a new perspective—a different lens through which to view individual clients and their symptoms.

Basic Family-Counseling Concepts

Although there are many different schools of family counseling, just as there are different individual theories of counseling, all family-counseling approaches share a focus on the family as a system. Case and Robinson (1990) suggested that family counseling is in a process of transition as descendants of distinct family-counseling schools are finding common ground and integrative concepts are proliferating. In defining a common theoretical approach, family counselors are moving toward a conceptualized model that could be viewed as emphasizing context, interactiveness, systemic relatedness, and multifacted functioning.

Nichols (1984) suggested a fundamental premise of family counseling as an orientation: "that people are products of their social context, and that any attempt to understand them must include an appreciation of their families" (p. 80). Family counselors view problems as existing both between people and within them; the focus is on interaction and the context (Searight & Merkel, 1991). Individual-counseling approaches may recognize the importance played by families in shaping the individual, but they generally assume that these influences have been internalized; thus, symptoms are seen as a result of conflicts within the person (Nichols, 1984). On the other hand, family-counseling approaches focus on current interpersonal interactions as most important, and view symptoms as a result of conflict between the individual and the environment. Individual counseling attempts to change how the person handles his or her own internal experience. On the other hand, family counseling attempts to change the organization and interactions of the family. The focus is on the family system and the individual within that system.

A second factor that distinguishes family counseling from individual counseling is the systems concept of circular causality (Bevcar & Bevcar, 1982; Fisch, Weakland, & Segal, 1982; Minuchin & Fishman, 1981; Nichols, 1984; Oliver, Lightfoot, Searight, & Katz, 1990). Individual theory has tended to have a monadic view based on linear causality, in which prior events are thought to have caused the present problem. Circular causality expands the view so that the family system is seen as a self-reinforcing circle of interactions. "There is a circular, continuous process of mutual affecting and reinforcing, which tends to maintain a fixed pattern" (Minuchin & Fishman, 1981, p. 14).

Family counselors also view the family system as always striving for homeostasis. As a living system, it (a) is governed by rules, (b) has a structure of hierarchies and boundaries, and (c) utilizes both positive and negative feedback loops to maintain a state of equilibrium (Bevcar & Bevcar, 1982; Fisch et al., 1982; Huber & Baruth, 1989). Many difficulties presented by individuals in therapy are a function of their striving to maintain homeostasis and becoming "stuck" in maladaptive patterns and rules that no longer apply to their changing developmental needs and circumstances. An inadequacy of fit between the system and the prevailing context has given rise to the presenting problems (Simon, 1992).

Finally, family counseling might be distinguished from individual counseling by its focus on multifaceted functioning (Huber & Driskill, 1993; Minuchin & Fishman, 1981; Nichols, 1984). Most traditional psychotherapies have attempted to diagnose difficulties, and this involves focusing on weaknesses and pathology. Although family counselors do not ignore pathology, there is an attempt to balance weaknesses with strengths. Families are viewed as having resources, "those chracteristics among family members that promote coping and survival, limit destructive patterns, and enrich daily life" (Karpel, 1986, p. 176).

A Case Study Illustrating Family Counseling with an Individual

To better demonstrate aspects of the family-counseling perspective as they are evidenced when working with an individual from a family-counseling perspective, a case study is used throughout this discussion. The client is June, a 30-year-old single mother. June and her 7-year-old daughter, Sally, live in an apartment attached to June's mother's home. Her mother is 55 years old, and they have always had a difficult relationship. June presented for counseling with symptoms of depression, and identified her main problem as her relationship with her mother. June feels her mother continues to interfere in her life and make excessive demands. Using a traditional individual focus, it might be possible to help June (a) gain insight into her feelings toward her mother, (b) develop behavioral strategies to help her manage her interactions with her mother, and/or (c) give her cognitive coping methods to deal with her distress in these interactions with her mother. All of these individual strategies have the potential to be helpful, but are also limited by their focus on the content and viewing the problem as being internalized within June. By focusing on the process and the underlying "rules" that guide June's interactions and relationships, more global and long-lasting change is possible because we can now address the difficulty as being both within June and between June and her family. We have moved away from concentrating on just the individual to a focus on patterns and dynamics in family functioning and are now intervening in the broader system. Focusing on the process changes how we view symptoms and behaviors; they are no longer seen as being isolated within the individual but are now also seen as being between individuals.

The individual counselor seeks solutions to change the individual; the family counselor looks for changes in both the individual and in his or her relationships. The focus is on process and interactions, not on content and interpretations. "Process is a term used to describe the patterns of negotiating that develop gradually through trial and error. Content refers to the issue under discussion" (Burnham, 1986, p. 11). Family counselors come to understand the process within families by observing interactions when the entire family is present. When working with an individual, the counselor is able to observe the interactions between the client and him- or herself, but must also question to understand interactions within the client's family system. Thus, in an early session with June, the counselor asks for a concrete description of an interaction between June and her mother.

Dr. D.: You say that your mother is always trying to interfere in your life and there is nothing you can do to change things. Can you give me an example?

June: Well, the worst is when she tells Sally that I don't know what I'm doing. I can't get her to do anything I say whenever Mother is around.

Dr. D.: Tell me about a recent time when that happened.

June: Let's see it was last night. To start with, Mother just walked in like she always does and I didn't really want her there. I was trying to get Sally to bed. I try to make it a game but she usually ends up just wanting more things and making more demands. So, I ended up getting really mad at her and yelling. Then Mother told me I was "acting crazy" again and she would take care of Sally. I just started to cry and left the room.

Dr. D.: What happened then?

June: I don't really know. Let me think. I guess Mother came in and tried to comfort me but I didn't want to have antyhing to do with her. Then she started trying to tell me how to do things again and I finally just went to take a bath. While I was doing that, Mother left and Sally just decided to go to bed by herself. I seem to be always trying to make Sally happy and to keep Mother from criticizing me but nothing works.

By working with the client to get a concrete description of one cycle between June, Sally, and June's mother, the counselor can begin to get a broader view of June and her depressive symptoms. From a family-counseling perspective, symptoms are also given new meaning and this leads to different therapeutic action. From an individual perspective, symptoms or problems are seen as expressions of some internal conflict. The family counselor looks at symptoms as also serving a systemic function in balancing or unbalancing the systems in which the individual is operating. Symptoms are neither formed nor solely maintained by the individual in isolation from others, but are created and sustained by interactions and emotional attachments between people in significant relationships (Nichols, 1984). Problems and dysfunction are seen to be related to the family system, rather than emanating solely from the intrapsychic problems of any one individual. Symptoms are a reflection of stress on the larger system; the individual with symptoms belongs to a larger family system. As Nichols and Everett (1986) stated, "... one person's symptoms may reflect both that person's disturbance and the relationship disturbance" (p. 36).

Looking at the cycle of interactions described by June, the family counselor views June's depression and her relationship difficulties as being circular rather than linear. That is, the depression contributes to the ineffective way she relates to her family, and this contributes to the depression. June may be suffering from a major depression or she may have a biological tendency to be depressed, but there also appear to be problems with the family's structure and rules that are maintaining and/or increasing the depression. June and her mother have neither a clear hierarchy nor boundaries. Now that June is an adult, this has also influenced the relationship that June has with her own daughter. Additionally, as suggested in the interaction described, the family may have a belief that "We must take care of each other and cannot have open conflict." June seeks to avoid conflict with Sally by not setting any real limits for her. June does not want her mother to come over now, but avoids conflict by not saying anything. Grandmother tries to avoid conflict by intervening when June gets mad at Sally and offering to take over to take care of June and Sally. Sally responds to the conflict between June and her mother by voluntarily going to bed, possibly to avoid further conflict and "take care" of June. A feedback loop can be identified in which (a) June acts to avoid conflict and feels responsible to her mother and/or daughter; (b) grandmother acts to care for June and Sally if they have conflict; (c) June withdraws, feeling more helpless and depressed; (d) Sally tries to smooth the conflict between June and her mother and take care of them; (e) all withdraw; (f) the conflict is unresolved; (g) June is more depressed; and (h) the conflict then resurfaces at some point and the cycle is repeated.

A family-systems view seeks to look at the individual within the system, not to excuse the individual or lessen individual responsibility, but to increase the leverage for change by recognizing that the system impacts upon the individual, just as the individual impacts upon the system. As another example, consider a family in which the father is an alcoholic. Individual treatment would focus on the father's alcoholism and might dictate inpatient treatment. The father would work on recognizing his addiction to alcohol and develop strategies to control it, such as increasing his self-esteem, learning ways to relieve stress, or joining a group such as AA. These will often prove successful until he returns home, and then he may find himself again drinking. If the focus of treatment included the family and viewed the father's drinking as a symptom of systemic stress, the counselor might have further explored the function that the father's drinking serves within the family. Perhaps the parents could not agree on how the children should be disciplined and often argued about this. Then the father began to drink and was no longer aware or concerned about the children, and the mother began to manage the children in her own way. Or perhaps the mother began to insist on managing the children her way, and the father responded by withdrawing and beginning to drink. The order of the sequence is not important, but the process is because it is here that we see the function of the symptom. The parents no longer fight about discipline. Although the father's drinking creates many new problems, it "solves" the discipline problem in the family. If this is not recognized and dealt with, when the father returns from treatment the problem returns with him and the cycle may lead to his renewed drinking or to his seeking some other way to escape. Again, it must be emphasized that we need not totally reject the hypothesis that the father may have a biological addiction to alcohol that must be treated. However, we must also look at the function of his problem for the family if we are to provide the most helpful and comprehensive treatment. Regardless of the specific unit (individual, parents, or family), the treatment plan must include strategies aimed at modifying the behaviors and structures of the entire family system.

Both the individual and the larger system are essential in understanding the complaint and its antecedents and consequences. "The individual holon incorporates the concept of self-in-context. . . . There is a circular, continuous process of mutual affecting and reinforcing, which tends to maintain a fixed pattern" (Minuchin & Fishman, 1981, p. 14). Understanding the circular nature of all interactions, patterns of behavior, organization of systems, and regulating rules, the family counselor is better able to take advantage of the reality of multifaceted functioning and to build on the strengths and resources of the individual and family.

Returning to a later session with June, we can see how the stage was set for change when June could recognize the pattern in her family interactions. In this session, June reports not only improvement in her depression, but also changes in her relationship with Sally. The counselor then moves to build on this competency to address June's relationship with her mother.

June: Things have really been great this week. After we talked about the cycle between my mother and I, I have felt so much more positive. I decided this week that it was time I started to act like Sally's mother instead of trying to be her friend all the time. I am always frustrated because her toys are all over the house. So Monday, I told her that she had to pick everything up by 8:00 and I would help or I would pick up the toys myself and keep them for the next day and she couldn't have them. I was so surprised because she was actually excited and kept checking to see what time it was. Just before 8:00 she hurried around and picked everything up.

Dr. D.: It sounds like you were able to feel comfortable being in charge of things and willing to enforce the rule even if it might make Sally unhappy.

June: Yeah, I always end up making her unhappy anyway because we end up in a fight when she won't help me pick up. I think she liked it better this way really.

Dr. D.: She liked knowing exactly what you expected and what she could expect from you. Do you suppose she will continue to be happy with the change?

June: Actually, last night she didn't pick everything up so I just took the books she left out and put them away. This morning she asked for them and did cry a few minutes when I said no but then she seemed fine. I guess it really wasn't so bad and we actually got over it quicker. I felt really good about how I handled it all. I just wish I could learn to manage mother as easily.

Dr. D.: Let's look at what happened with Sally and see if you can use a similar approach with you and your mother. What do you think was different this time with Sally?

June: Mostly, I think it is that I decided what I wanted and didn't give in.

Dr. D.: Has there ever been a time with you and your mother that you seemed able to do that?

June: Once when we weren't living together. I decided I would call her each day and go take her out or visit three times a week and that is what I did. She asked me to come more, but then it seemed we just settled into a routine and she was fine.

Dr. D.: I am struck by the similarity between that solution with your mother and the way you worked with Sally this week. In both cases, you decided how to take care of them by offering to help but also set some limits in order to meet your own needs.

The session continues with ways that June might act on the "new rule" and take care of both herself and her family, even though there might occasionally be conflict. The focus is always on both June as an individual and on her relationships within her family system. There is a balance between recognizing the difficulty as real and disturbing, but also building on existing strengths and resources with a recognition that all people have situations or times when they function well, when a difficulty is being dealt with adequately (Huber & Backlund, 1991). Family counseling with June has provided her with more confidence, leading to fewer helpless, hopeless thoughts. This has not only provided some relief from her depression, but also changed her relationship with her daughter. This change can then be used as a resource to build on in addressing her relationship with her mother. The goal of changing both realtionships and individuals is being addressed. When there is a balance between addressing problems and affirming strengths of all family members, it is more likely that all will be able to adapt in a more positive way to change. For example, when June's mother's interference is reframed as her way of caring for June, June moves from feeling depressed and oppositional toward her mother to looking for alternative ways of dealing with her mother to lessen this particular way of caring. The family-counseling view moves away from blame by focusing on circular causality.

Once the family structure and rules are understood, the individual client and the family are encouraged to stay the same in many ways, but change in some small ways. June is able to take care of herself and still care for her family so that she is not seen as rejecting and indifferent by her mother or daughter. As she changes, the cycle of interactions between them also changes, and with hope, they all learn to connect in a new, more balanced way.

Summary

The power of family counseling is evident whether the client is an individual or an entire family. Change happens both within the client as well as in the client's relationships. The individual client and the family system move to a state of dynamic equilibrium instead of being "stuck." As the individual learns to modify the family rules, this modification is transferred to the family through the client's actions and reactions. In the modification, the individual and the family learn to be more functional as they adapt to change; they are then able to mobilize alternation patterns of interactions. As the system and the individual become more flexible, they are better able to build on their strengths and utilize their individual and collective resources. Additionally, individual symptoms of system stress are minimized or eliminated. Not only does the system begin to function better, but each individual within the system also experiences a greater sense of personal well-being and empowerment. Optimal functioning occurs through dynamic balance.

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PART III

THE TREATMENT CONTEXTS

8

The Family-School Intervention Team (FSIT) Model: A Metalevel and Multisystemic Approach

William H. Quinn
Jane Hill
Gail Wiley
Damond Dotson
University of Georgia

Dwayne was an 11-year-old fifth-grade student. He was above average on standardized test scores. He performed satisfactorily in all of his subjects periodically. He would have a correct answer to a teacher's question when other students in the room would not be able to respond. However, he was often talking at inappropriate times, physically intimidating on the playground, and unable to sit in his seat for a significant period of time. A home visit by the consulting team following a school referral revealed the following: (a) Dwayne's mother had sickle cell anemia and would require Dwayne to prepare meals when she became symptomatic; (b) Dwayne had a 7-year-old sister who helped him perform household tasks; and (c) there were infant twins in the home who were on monitors because another of mother's children had died of Sudden Infant Death Syndrome (SIDS). Dwayne knew his father and occasionally saw him in the local grocery store. However, neither had desire to spend time with each other. The mother's family was 30 miles away and could offer very little help. Mother moved to town primarily to be near her physician due to ongoing medical care needs. Mother had become extremely frustrated with the school because they would contact her only when Dwayne was behaving poorly. The school reported Dwayne's intermittent failing, but provided little guidance to the mother regarding how she could help. The entire family had little social support, except for the church, which was accessible only when Dwayne's mother could get herself and the family there. Whereas Dwayne's sister had two girl friends to play with next door, Dwayne had only one friend who lived a half mile away. He rarely received permission to walk there unless mother was feeling well and the younger children could be accommodated without him.

Family Influence on School Success

There is a substantial accumulation of evidence indicating that parent involvement improves student achievement (Becher, 1984; Gordon, 1978; Henderson, 1989). Programs including parent involvement produce students who perform better than programs that are otherwise identical but do not involve parents. Likewise, schools that have strong positive interactions with parents outperform schools that do not relate well with parents (Becher, 1984; Gordon, 1978; Henderson, 1989). Overwhelmingly, research has indicated that school personnel in varying partnerships with parents is an approach with tremendous potential for positive effects on learning and behavioral adjustment of children (Atkenson & Forehand, 1978, 1979; Ayllon, Garber, & Pisor, 1975; Clements & Alexander, 1975; Gardner, 1974; Gatti & Coleman, 1976; Lahey et al., 1977; Lewis, 1982; Sparrow, Blackman, & Chauncey, 1983; Susser, 1974). In contrast, teachers and parents know well the frustration and futility of working separately (Featherstone, 1980; Sarason, 1982).

These results go beyond the short term and apply to economically disadvantaged students as well as children from more fortunate backgrounds (Clark, 1983). Some of the benefits shown include: (a) higher grades and test scores, (b) long-term academic achievement, (c) positive attitudes and behavior, (d) more successful programs, and (e) more effective schools (Henderson, 1989). The educational literature is overwhelmingly supportive of the importance of involving parents, especially in early cognitive development (Becher, 1984; Gordon, 1978; Henderson, 1989).

Bronfenbrenner (1986) described an ecological perspective on the levels of systems within society. This included various systemic levels such as the individual, the family, the school, and the community. He identified them as microsystem (parental goals, expectations, childrearing practices), mesosystem (beliefs and values of the culture, and the social and religious institutions including schools), exosystem (parental work environment), and macrosystem (economic, legal, political conditions of the culture) levels. The model argues for inclusion of larger systems as an influence on the child through the influence of the parents. He described several studies that demonstrate the reciprocity of the family-school linkage.

Parental involvement in school is strengthened when teachers enlist parental support for educational goals. Teachers can elicit such support by periodically informing the parents of their child's progress, by personally inviting parents to the school for conferences or meeting with them in the home, and by occasionally sending brief progress notes home with the child (Bronfenbrenner, 1986). This concept logically extends into the aforementioned body of literature concerning the impact of the family on a child's school performance. Several programs exist in which family counselors work with school-related problems to incorporate this greater systems perspective (Amatea & Sherrard, 1991; O'Callaghan, 1991; Weiss, Edwards, Zelen, & Schwartz, 1991; Wetchler, 1986).

There is no way around the idea that the systemic perspective must be acknowledged in examining child and family behavior within the school context. In our current study of juvenile first offenders, there are strong associations between academic failure and school suspensions and variables pertaining to family- and community-level characteristics, such as prevalence of single-parent family structures, family drug/alcohol use, poverty, and history of criminality in the family (Quinn & Gale, 1992).

In a persuasive article reporting the results of a study on academic achievement of over 200 Indo-Chinese refugee families in several cities in the United States, evidence was overwhelming that parents were essential to their children's educational success (Caplan, Choy, & Whitmore, 1991). Parents set standards and goals for weeknight evenings that facilitated academic progress. This occurred even when the parents' lack of education and English proficiency were evident. In these homes, the tables were cleared, chores were completed, homework began, older children helped younger siblings, and stories were read. Instead of personal efficacy, there was the presence of a family efficacy. Parents who attributed greater importance to fun and excitement had children with lower grades, whereas parents who emphasized the values of their past family history had children who received higher grades. In sum, studies on family influences on school success document the significant role of families in school outcomes.

The Role of the Family Counselor

Grounded in a systems perspective, family counselors are aware that the context in which a child develops has critical impact on the child's developmental trajectory. A young child is primarily influenced by the home environment and the family. Later, the school becomes instrumental in developing the child's cognitive skills, and also significantly impacts the social and emotional development of the child. Consequently, when a family is referred to a family counselor for a school-related problem, or any time a school-age child is the identified patient, it is important for the counselor to include both family and school environments in the conceptualization of the situation (Eno, 1985).

Family counselors are in a unique position in their ability to see a child's difficulty from a systemic perspective, including both major systems in which the child is embedded: the family and the school. By understanding the functions and dynamics of the school-family interaction, family counselors deal with a child's problems without treating the youth as a self-contained organism (Okun, 1984).

The family counselor is positioned at the interface between the family system and the school system to restore family-school communication, thus advocating family-school intervention (Lustermann, 1985). Fish and Jain (1988) also incorporated this systemic approach and suggested the use of Minuchin's structural theory as a framework for intervention. A "transcontextual" model of systemic intervention was developed by McGuire and Lyons (1985). This approach considers the focus of importance to be the identification of activities in the family that are prompting the student to have difficulties at school. At the Brief Family Therapy Center in Milwaukee, WI, Kral (1988) developed a home-school intervention model based on the Solution-Focused model. He and others have had wide success using this model with school-related problems, as well as training school personnel to utilize solution-focused techniques in dealing with children and their families. Family counselors create change by altering system structures and communication patterns in both the family and the school, rather than by treating the child as separate and discrete (Okun, 1984). This notion serves to ground all of our interventions.

Specific Assumptions of an Underlying Theory of Change

It is clear that many students enter school ill equipped to learn due to physical problems (lack of adequate medical treatment, hunger) and family environments impoverished and absent of stimulation. Families affected by poverty may not possess a strong cognitive sense of the vital linkage between family environment and academic success of children. Therefore, a recommendation by a teacher or principal to a family that it schedule an appointment with a family counselor is confusing to the family and defies logic. Furthermore, a direct effect of poverty on some families results in a lack of transportation access to the offices of family counselors.

At the same time, schools are frustrated because of their lack of success using individual interventions with difficult students. For example, a school counselor who meets individually with a troubled student and provides encouragement or messages directed at self-esteem recognizes that such a student will likely be going home at the end of a school day to a dysfunctional or deprived family environment, or, in Dwayne's case, a terminally ill mother and an array of household tasks. Such an approach becomes a weak and inefficient intervention.

The model discussed in this chapter makes a number of assumptions that underlay a theory of change:

1. Parental behavior changes affect children's behavior and, consequently, academic and social improvements.
2. Teacher and school behavior changes affect children.
3. Making the problem-solving collaboration more convenient is essential. Asking parents to choose a time and day for a meeting, having meetings at the school or home, and considering transportation needs and work schedules are important. In this way, a parent is more likely to respond cooperatively when given choices. Asking, "Can you meet on Tuesday at 4?" and receiving a parental response of "No, I work then" or "No, my daughter has a Brownie meeting then" is not as effective as saying, "What is a time that you (and your husband) could meet with us?" Including the identified child exhibiting school failure or behavior problems is often helpful.
4. Empowering parents via more participation with the school personnel in decision making is crucial. Our neutral position without an agenda of what has to happen prior to a meeting is an important ingredient. In essence, the floor is open to any participant who wishes to express concerns. The FSIT facilitator functions to steer the conversations toward a consensual pragmatic plan. Essential ingredients include questions, paraphrasing, and clarification.
5. The chances for success in engaging parents in the intervention process increase when conversations center around academic

needs and progress. Few families would admit to apathy regarding their children's academic life. Parents want to be, or want to appear to be, advocates of their children's education. Therefore, engaging a family in the intervention process is more likely when discussion centers on the child's academic life. For instance, a prefacing statement to any comment made by a facilitator to a parent might be, "I know you are interested in the well-being of David's academic future, Mrs. Howard, and I want to see if we can . . ." (i.e., schedule an appointment to talk about it, come up with a homework plan at home, etc.). To discuss ideas like David's temperament or social relations is only helpful as a procedure that builds an alliance between school and home or is used as a sensible linkage to an academic intervention plan. If modifying temperament or peer-relation skills becomes the targeted goal, the chance for family collaboration and efficient and significant change is unrealistic. Consequently, such failure in reaching the goal promotes pessimism and helplessness. Such a linear goal can also imply that the responsibility for arriving at a solution rests with the child. This orientation conveys blame and places too great an expectation for change on the child. Such an approach weakens intervention because parents and school representatives are more tempted to disengage and wait for the child to change some previously specified problem behavior.

6. It is important to break intervention strategies into small steps and to go slow. After all, the problems at hand have not typically surfaced within the previous 24 hours. Small success builds confidence in all participating members. Trying to do too much too soon is not respectful of the range of influences playing upon the problem. There are occasions when predicting a relapse after positive change is timely and appropriate.
7. The search for strengths is an underlying facet of all communication processes occurring within the decision-making model. Labeling behaviors as good or bad, right or wrong, is avoided because it is not conducive to this aim. Instead, highlighting abilities and discovering the aspects of individual or family functioning that are effective or satisfying are sought.
8. School meetings traditionally are loaded with conversation that is negative or inhibiting. Talking at levels of explanation are also unhelpful because analysis and causation are not concepts that are congruent with solutions. In essence, participants are encouraged to move from "gripe, gripe, gripe" to "what can we do to change it?"

9. The concept of "dichotomy" is expelled from the model. Examples of the kinds of dichotomies that are destructive are: (a) being a good child or a bad child (or good parent or bad parent), (b) having a good or bad childhood, and (c) being a capable or incapable student. This misguided assumption that a child should be classified in this way to be understood is often expressed in triadic networks in which the school and family, or members within one of these systems, utilize the dichotomy to differ with each other and conveniently reduce their own personal responsibility. This is evident in the adversarial relationship that develops around disagreements about who is at fault: the family, the child, or the school. Carl and Jurkovic (1983) reported that when a school refers a family for counseling, a problem often exists in the relationship between the home and the school. Adding further evidence to the formidable challenge in engaging multiple systems in child intervention, Chamberlain, Patterson, Reed, Kavanagh, and Forgatch (1984) found that agency referrals had higher within-session struggle scores (establishing a collaborative set) and were more likely to drop out than did self-referrals. Schools could be viewed as agency referrals. Thus, the FSIT emphasizes collaboration to reduce the struggle between systems that can occur.

Implementation of the Model

A unique opportunity arose in our community to put this perspective into practice through the Family Counseling Service in Athens, Georgia (a United Way agency) and the McPhaul Marriage and Family Clinic at the University of Georgia. The Family Counseling Service had instituted a program, the Student Assistance Program, in which student interns from the counseling or social work department at the university were placed in each public school in the area in order to be available to students and teachers. They were to identify and work with students experiencing personal or school problems. These interns assessed each situation and its severity and, when appropriate, made recommendations to the Family Counseling Service for higher level intervention. In some cases, this led the family into family counseling. However, after several months, it became evident that there were families that were resistant to following up on recommendations of the intern for family counseling. Families would not make their appointments, or would express their confusion regarding the purpose of such meetings as they pertained to their children's academic progress. At this point, the family-school intervention project began to take shape. Employing the larger system perspective described previously, a service model for dealing with these difficult or stuck cases was initiated.

A description of the community context is necessary because an understanding of the environmental influences on intervention is crucial to success. The county served by the FSIT has unique characteristics that must be considered in the development of a community-intervention model. The area has a substantial minority rate: 27% of the local population and 52% of the student body in public schools (Youth Empowerment Systems Report, 1992). The number of single-family homes is high (69% of minority youth). The prevalence of the single-parent family creates a set of unique difficulties that requires intervention to be sensitive to this family structure. For example, Wetchler (1986) offered an intervention model that is partially driven by the goal of realigning the family hierarchy. In most examples given, a two-parent, intact family exists. Our project attempts to respectfully address the common occurrence of single-parent families, with emphasis on collaborative problem solving among school and family participants that more evenly distributes shared responsibility. The high school dropout rate for all students is 18%. The frequency of poverty is high, with 27% of families earning less than $10,000 per year—higher than Georgia's average of 20%. In 1984, 950 families in the community were on Aid for Dependent Children; in 1991, the number was 1,663. Many of the families in this project are of African-American descent. A family's view of a school is influenced by race and culture. For example, Jewish families place a high value on education as a tool for advancement (Herz & Rosen, 1982), whereas many poor African-American families believe education to be of value but view the school as a reflection of White society that impinges on their lives (Hines & Boyd-Franklin, 1982). Thus, in our approach, a concerted effort was made to develop a collaborative spirit in the problem-solving conversation that fosters family confidence.

It became evident to us that there were already many systems from the community engaged in these cases. Included, but disconnected from each other, might be the state family-service agency, school social workers, Family Counseling of Athens, school psychologists, principals, teachers, and possibly others. All of these systems had to be dealt with on some level, and it became evident that in many cases it could be an awesome undertaking. Hence, our major objective was to engage this systemic confusion and boundary ambiguity in such a way as to attain a clear and workable plan to enhance the child's school functioning. Our model includes several steps that are described next. Flexibility became our most important tool in dealing with the vast variety of situations in which we found ourselves engaged.

The first step in the FSIT model is to identify the families needing services. A letter describing the program and its services is sent to all schools in the area, public and private, early in the school year. A meeting is then held to answer questions for the schools and allow the team to assess their degree of interest. The next action is to identify a referring person at each school that wants to participate in the program. This person can be the vice principal or the administrative person who is in charge of discipline in the school. Sometimes our contact is a school counselor if the school has one. We allow the school personnel to initiate contact with the intervention team to ensure participation and cooperation on their part. The liaison school representative is self-selected or selected internally by the school so as to build on initial motivation and purpose.

Children and their families who become referrals to the FSIT are exceptional cases; they differ from routine referrals made to outside agencies. Criteria remain flexible and somewhat at the discretion of the referral source, but still include severe and ongoing academic and behavior problems on the part of the child, and minimal or no family involvement in the child's school life, even when efforts are made by the school to engage them. One of the referral sources defined these children and families as "the ones that everybody knows" because of their negative reputation in the school.

A case-example might clarify this referral process. An early referral received was for two stepbrothers whose behavior at school was extremely disruptive in both their classrooms; also, their father was so alienated from the school that he refused to talk to school personnel. Child abuse had been suspected, but the family was cleared after an investigation by Department of Family and Child Services. At the point that the team entered the case, the boys were almost uncontrollable in their second- and third-grade classes, and the school had no communication with the father, who was the custodial parent. The father had built up hostility toward the school for reporting the family for possible child abuse. This situation had existed for over a year. At the father's request, the team saw the father initially at the McPhaul Marriage and Family Clinic, the site where the authors work, instead of the school. After developing an alliance with him, a meeting was scheduled at the school between father and school personnel, with the team present.

The second step in the FSIT model involves identifying all the members of the system that maintain a particular school problem, and deciding what setting would be most appropriate for an initial meeting. This task requires a careful assessment of the current situation as well as all previous interventions implemented. Ideally, all identified subsystems are represented because the goal is to help the system, which includes the child, function more effectively. The presence of the family, including as many extended family members as possible, is of primary importance. The child may or may not be present. If it is felt that the focus on the problem behavior would be too discouraging to the child and would hamper the intervention process, the child may not attend. In these cases, the child may be seen separately for a meeting by a member of the intervention team.

A scheduled time with school personnel who are involved is arranged, and the meeting is held at the school. The principal or assistant, a school counselor, and appropriate teachers are solicited for the meeting. Although a meeting at school is the team's preference, in actual practice it is necessary to be flexible in the interest of engaging difficult families, and a number of exceptions can be made. Home visits are done in cases in which an important family member refuses to attend or is unable to attend because of chronic health or transportation problems. For example, the case presented at the beginning of this chapter included a home visit made initially to a single mother whose 6-month-old twins were on monitors for SIDS due to an earlier death of a sibling. In the other case mentioned previously, the meeting was held at the McPhaul Marriage and Family Clinic with FSIT members and the single father, whose relationship with the school had ground to a halt.

However, meetings can be most productive when the family and all those at the school who have interaction with the child can attend the meeting. School personnel may include: (a) the school principal, (b) the assistant principal, (c) the classroom teacher, (d) the school counselor, and/or (e) special teachers such as the behavior disorder teacher. Others who may be involved are: (a) the school psychologist, (b) the school social worker, (c) a classroom teacher from an adjoining classroom, or (d) the teacher's aide. In one recent case, a male student teacher was targeted as a primary child advocate and change agent for a troubled male student. In some cases, a worker from the community may be involved, such as a family-services worker. The goal is to engage the resources of as many of the subsystems as possible, within the problem system, to create some positive change in the situation.

The third step in the model is to carefully facilitate the initial meeting. The purpose of this meeting is to gather information about the problem and to begin movement toward solution. At this meeting, a number of issues facilitated by the team are addressed. First, the question is asked: "What is the problem, specifically?" Parents and teachers may not see the child's behavior in the same way. Teachers may view certain behaviors as problematic and disruptive. On the other hand, parents may view the behaviors as less of a problem because they require less organization in the home. The child's behavior may reflect a lack of fit between the two socializing environments. In these situations, intervention will focus on the acknowledgment of different sets of rules in the two settings, and working with parents and teachers to establish some continuity between settings.

Next, a variation on the questions "When does the problem occur?" and "What is the context of the problem?" are asked. Variation is accepted because the language used is vital to the extent to which family members comprehend the ideas embedded in the questions. In some cases, the questions are more important than the answers because they shape the information and direct the problem-solving conversation. These are important questions, the answers to which can save a great deal of time in resolving the problem. For example, Kevin's kindergarten teacher involved the team due to his unpredictable angry outbursts. After keeping a journal of when the outbursts occurred, the teacher discovered that the outbursts usually occurred on Wednesdays. Further exploration revealed that Kevin usually spent Tuesday evenings with his father, and returned to his mother's house well past his usual bedtime. Intervention involved problem solving around ways in which the child could go to bed at the same time each evening. A subsequent question is: "What is the history of the problem?" Fragments of this question became: "How long has it been going on?" and "Has it worsened or improved over time?" The answers to these questions can reveal a connection with concurrent events in the child's life.

Some problems with a child's behavior can be seen as normative adjustments to family life-cycle events (Carter & McGoldrick, 1988). Because family transitions or changes in the family context influence the child in the school context, family history is explored to look for events that could be influencing the child's behavior. Events such as (a) divorce, (b) remarriage, (c) the birth of a sibling, (d) the death of another family member, or (e) another child's leaving home can affect a child's school performance and behavior. The team considers how the family is handling these challenges and alterations in family roles. Intervention involves managing the child's behavior in school while facilitating the child's, and perhaps the family's, adjustment to life-cycle transitions. Many times, parents are handling the adjustment well, and teachers may benefit from seeing the problem as a normal transition period. For example, Kevin's parents divorced when he was 3 years old. A year later, Kevin's mother remarried and gave birth shortly after the beginning of Kevin's school year. Adjustments to such changes are difficult even for adults. Therefore, it is not surprising that Kevin was having difficulty handling these changes while at the same time adjusting to his first year of school. Transition to first grade can be a tremendous adjustment process on its own, without the added family stresses experienced by Kevin.

Further questions in the first meeting center around solutions. "What attempts have been made at resolution thus far?"; "What has worked?"; "What has not?" By avoiding interventions that have been tried and did not work, the team can maintain its credibility as well as convey a sense of respect for parents, teachers, or administrators who have already made several attempts at solving the problem prior to the team's arrival. Knowing what has not worked also saves time by eliminating unsuccessful options (Fisch, Weakland, & Segal, 1982).

Intervention can be aimed at the child's behavior at school, at home, or both. Differences in the ways that teachers and parents respond to the child's behavior are generated in consultation with parents, teachers, and the child. Parent–teacher communication is facilitated so that these parties can begin to monitor the child and work together to find solutions. This process is similar to nuclear-family counseling, which focuses on creating a parental coalition to establish an executive subsystem (Minuchin & Fishman, 1981). When parents and teachers are united in their efforts in influencing a child, the child will find it more difficult to maintain an unwanted behavior. We have found this to be particularly vital for single-parent family structures.

With regard to the first meeting, it is important to avoid or counteract the feeling of blame. The avoidance of placing blame on one person or party is a large part of the intervention process. Many parents whose children have a history of school problems have an adversarial relationship with the school, as mentioned previously, and are leery of such meetings. A strategy known as externalizing the problem (White & Epston, 1990) has been used with success with families where blame is problematic. For example, a child who is disruptive in class might be described as "having the jitters." Creative questions using these terms can be asked of the child: "How long have you had the jitters?" "Do the jitters stay in the classroom or do they follow you home every day?" By conceptualizing "the problem" as some external entity that seems to follow the child around, one can discern context specificity such as whether the problem exists in both home and school contexts.

Additional questions can be asked to lead the child, parents, or teachers to possible solutions. For example, a child might be asked, "What could you do with the jitters while you are in class and need to concentrate on your work?" It is especially important to avoid a blaming stance with parents. Parents are approached as consultants who are experts at handling their child's behaviors. Approaching the problem in this way communicates the following message: "There is this problem out there, that affects all of us. We all need to work together to discover how we might find a solution."

As work with the FSIT project evolved, it was discovered that making specific decisions about who was responsible for each part of the intervention plan was necessary. That way all participants knew what their own and others' responsibilities were, and greater accountability for following through with changes was encouraged. Another helpful idea was to set a follow-up meeting at the time of the initial meeting. Thus, a time frame was established within which interventions were attempted, ensuring that evaluation could be done in a timely manner to prevent useless efforts if attempted solutions were ineffective.

Solutions that emerged via the FSIT were varied, idiosyncratic, and creative. They often required enlisting other community organizations. For example, in one case a fifth grader who often had to act as a parent for his siblings was given a scholarship, in response to a request by one of the authors to the after-school program of the local YMCA, so that he could develop friendships and self-confidence by having a chance to interact with peers. His mother agreed to do without his help after school, and to provide transportation home from the "Y," which was new for her. Another example was the school's providing a weight-lifting program for an overweight teenager, to be monitored by the school liaison and to be contingent on his regular attendance at school, which had not been meeting state requirements.

The second and subsequent meetings of those involved in FSIT efforts to address a particular persistent school behavior problem take a similar form. Evaluation of the initial plan is conducted and adjustments are made. Progress is underlined and supported by the FSIT. This is a very important aspect in establishing positive changes as "permanent," and allowing members of the system to experience themselves as competent and capable in managing a child's behavior or promoting success. There is a tendency to focus too extensively on problems, so the discussion of solutions and strengths, partial or not, is an important function of the team.

If difficulties have arisen over the interim since the last meeting, decisions are made on how to modify the former plan in much the same way that it was formulated originally. Again a follow-up meeting date is set. This process repeats itself and continues until the problem is resolved.

It is important to underline that the FSIT remains a resource for the child, family, and school on an ongoing basis. Because these are high-risk students who require ongoing support, cases are not seen as closed.

One of the most valuable changes that seems to occur as a result of involvement in this project is the change in the parents' perceptions of the school. The family is able to see the school as helpful and less adversarial, rather than a threatening or chastising bureaucracy. Often this change is sufficient to allow the family and school to work out future problems more cooperatively, without necessitating the intervention of the FSIT.

Fostering a Meaningful Conversation

Meetings among family members, school personnel, and facilitator can be inefficient, time-consuming, or destructive unless certain features of communication are present. These features include the following.

1. Identify the purpose of the meeting. This is important because competing cross-agendas can hamper the constructive interaction needed to achieve the goal. Typically, the purpose of the meeting is to solve a particular problem. Thus, some consensus about the nature of the problem is necessary.
2. Involve each participant early in the meeting. Help everyone to feel a sense of belonging to the social group. Invite thoughts and feelings to be expressed in order to promote an understanding of each other's experience related to the problem. A participant who dominates the conversation is likely to force a shut down of thoughts and feelings of others and prevent any sense of shared ownership of the problem.
3. Work toward a description of problem behavior that eliminates a perception of personal inferiority or inadequacy. Describe a behavior as well intentioned (i.e., wanting to please or help mother) or caring (i.e., protecting another family member).
4. Weave pieces of information together in a fabric that provides an image of the circumstances and the context in which the

problem is embedded. Use patience in doing this so as to utilize each other's expertise and acknowledge the constraints operating on each person. Work toward a solution that transcends those constraints or renders them irrelevant.

5. Consider all community resources relevant to the problem. These resources include community services available at reasonable costs, and persons with a particular expertise. Avoid an overreliance on professionals who often work independently and with little regard for, or familiarity with, the work of other professionals or situations outside their awareness. Minimize the use of experts who tend to label children and thereby convey inadequacy or little possibility for change.
6. Include the child in the conversation as an equal participant. Avoid questions that require a "yes" or "no" response. To fully understand the child's predicament or problem, open parameters to include a storytelling. For instance, ask "Tell me about your visits to your father's house on the weekends" or "What are your evenings at home like?"
7. Review the plan before terminating the meeting. Recording the plan can also be effective because it suggests an official quality to it, much like a written contract (Quinn, 1987). Close the meeting by asking if there are any questions.

Case Vignette One

Fred, age 8, and Frank, age 9, were stepbrothers. They lived with Fred's father, Mr. Harris, who had custody of them. Another sibling, Charles, age 16, lived with them. Carol, age 2, lived with grandparents. The two younger boys had many behavior problems at school. They were in the same grade, but different classrooms, because Frank had been held back for a grade. Their father had developed a very suspicious attitude toward the school, partly because he had been reported by school personnel for possible child abuse, although an investigation did not confirm the report. He had also been recommended for family counseling but did not follow up on the recommendation. When contacted by an FSIT member at the school's request, he agreed to a meeting. Team members were able to discuss with Mr. Harris his genuine concern for his sons and his feeling of "being at the end of his rope" as far as what to do about them. He agreed to return for another meeting. At this point, the end of school was near. Mr. Harris sent the boys to their grandparents for the summer. The team suggested the possibility of splitting the boys up in the fall to break up their negative coalition. Mr. Harris decided to have Fred remain with his grandparents in September, and Frank returned home. After this decision, Frank's behavior improved greatly. The team did not hear from Mr. Harris again until he had decided to bring Fred back home. He came with the boys for a couple of sessions to problem solve how to set limits with Fred so that he would not be able to sabotage his stepbrother's progress. Again there was a hiatus of several months. When Fred's behavior at school began to deteriorate, Mr. Harris called again. This time a meeting was set up at the school, which Mr. Harris agreed to attend. At the meeting he heard many good things about Fred, as well as problems. His relationship with the school seemed to have improved greatly. After this time, although the path for the boys was not smooth, the FSIT has not been contacted again, apparently because Mr. Harris seemed to feel empowered himself to deal with the school on behalf of the boys.

Case Vignette Two

The team was contacted to assist with Jason, a 6-year-old in kindergarten. The school teacher was concerned about Jason's emotional outbursts in the classroom. She described him as manipulative and agitated when he did not get his way. Furthermore, he was caught attempting to harm an animal kept in the classroom. The mother was given as the parent to contact, and a meeting was arranged with her and the teacher.

In the meeting with the mother, it was learned that Jason's parents were divorced 2 years prior to contact with the team, and that the parents' relationship was characterized by ongoing distance and hostility. The mother revealed that she wished her son had no contact with his father, but realized she had no legal right to cease such contact. The teacher noted that Jason usually exhibited behavior problems on Wednesdays; Jason spent each Tuesday evening with his father. It was hypothesized that the child was acting out the standing, silent conflict between the parents. Jason provided drawings depicting him and his father separated from his mother and her husband by an enormous safe dropped by aliens. Given this theme of fear of separation from his father, it was decided that Jason's father should be included in the team's efforts.

A parent–teacher meeting and discussions alone with the father revealed that the father was feeling pushed out his child's life and feared losing contact with his son. Intervention then focused on Jason and his drawings. We facilitated discussion of how he might cross the enormous safe in order to be part of both families. Jason became excited at this prospect, describing tunneling and climbing that would allow him access to either family. This intervention came about through conceptualizing the behavior problem in school as the only safe place Jason could act out the anxiety associated with trying to be part of two families that were opposed to one another. Follow-up contact with the team involved joint meetings with both parents to reinforce the feeling of continuity between family settings that Jason was beginning to experience. As a result, the father and mother began to experience a lessening of conflict, and communication flowed more naturally. Follow-up contact with the school teacher revealed that Jason's classroom behavior was more manageable and caused much less concern.

Case Vignette Three

In the case of our opening clinical illustrations of Dwayne and his family, the initial contact made by the team was to the home (although this is not always required). Several key observations were made: (a) It was clear that mother's sickle cell anemia created unusually high responsibilities for Dwayne and his sister. They were required to prepare meals and care for the twins (particularly when mother was most symptomatic). (b) Dwayne had no after-school opportunities to participate in peer activities (clubs or sports). His closest friend was one-half mile away. (c) Dwayne was extremely polite in the home, offering us pieces of candy and making sure that we sat in the best chairs in the house. (d) Dwayne was very responsible, caring for his baby twins and preparing meals. (e) Mother was isolated and overworked.

The interventions chosen were pragmatic and specific. It is important to construct solutions that have a reasonable chance of success and have a purpose that can be understood by the family. In this case, several steps were taken: (a) Meetings at the school including the mother, teacher, student teacher (a male who developed a close bond with Dwayne), and the principal. The collection of school personnel met with the team. Suggestions to the teachers about how their responsibilities for teaching Dwayne and managing his behavior were made. The teachers were assured that their frustrations were understandable and that small successes had been made up to that point. (b) An appointment was made with the local college to have Dwayne tested for possible consideration into the gifted program (the school system had too big a backlog to test Dwayne at the time). (c) The local YMCA was contacted to inquire about scholarship help for Dwayne and his sister to attend after-school sports programs. Dwayne's sister was included because mother was concerned that if Dwayne's sister were not included, Dwayne would think that participating in youth sports at the Y after school would appear to be a reward for bad behavior because his sister was doing fine and yet would be deprived of the opportunity. (d) A plan was implemented whereby each Friday Dwayne's teacher would send home a report of Dwayne's work performance. Dwayne's mother would initial the report over the weekend, and Dwayne would return it on Monday. It was decided that a poor report would not lead to retraction of the YMCA program because Dwayne's individual development required such contact with peers and an opportunity to be away from the home.

Conclusion

These cases illustrate the utility of a multisystemic collaborative approach to altering children's academic and behavioral difficulties. The family is an integral part of the change process, therefore a family counselor plays an active role in engaging all relevant human systems and fostering meaningful conversations in the professional network. As Ianni (1989) warned, if collaboration is not valued then youth are "individually and collectively alone amidst a maze of institutional contexts which alternatively compete for primacy in authority and protest their inability to deal with the task alone" (p. 26). It has been our experience that this approach promotes equality, cooperation, and a shared sense of responsibility across family, school, and community networks.

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9

Individual to Family-Systems Thinking in the Health-Care Context

Kathy Cole-Kelly
Metro Health Medical Center

Making the transition from individual to family thinking and treatment is an exciting metamorphosis for anyone working in a medical setting or with patients coping with medical illness. Because most medical events occurring to an individual have multiple impacts on all family members, it is difficult to imagine the handicap one would experience by limiting the focus of treatment only to the patient. The individual focus prevents the practitioner from capitalizing on all the resources a family can offer to help maximize coping and minimize suffering.

A family counselor has many opportunities to work in the context of medicine: (a) as a collaborator with primary-care physicians in private or public group practice, (b) as a teacher in an academic primary-care medicine training program, (c) in a particular unit of a hospital such as a chronic illness or oncology unit, or (d) in independent practice with a specialty in working with families with life-threatening or chronic illnesses. The theoretical training of these family counselors covers the broad spectrum of family-counseling approaches: strategic, structural, reflective, experiential, and so on. However, whatever the theoretical approach and training may be, there are fundamental family-counseling concepts that merit special consideration for anyone working in a medical context or with a family encountering a medical event.

This chapter describes eight core concepts that can be adapted to a family counselor's specific therapeutic orientation. Next, the chapter describes medical contexts in which family counselors can make a contribution. In conclusion, it describes evolving developments for family counselors in medicine. Systems theory, on which all this is based, is not focused on because it is well addressed in other chapters of this book. Throughout this chapter, however, is the assumption that one making the transition from individual to family thinking in a medical context embraces systems over linear thinking.

Core Concepts in Making the Transition from Individual to Family Thinking

Family Structure

The most significant writings on the concept of structure in family systems have been by Salvador Minuchin with his Structural Family theory (Minuchin, 1974). The structural components reveal how the family is organized. Minuchin described the organization of the family as the critical determinant of its functioning. Important structural concepts include: (a) clarity of hierarchy (who is in charge, has influence and power) and (b) clarity of boundaries (how permeable or rigid the invisible walls of access are between members) within a nuclear family, between the family and the extended family, and between the family and the external world with which it interacts. Some of Minuchin's conceptions of family structure (such as hierarchy) have come under close scrutiny by feminists in the field (Luepnitz, 1981; McGoldrick, Anderson, & Walsh, 1989), resulting in many family counselors relaxing some formerly held ideas of how a family "should" be structured. However, structure of the system is an important concept to explore when working with a family in a medical setting. Being open to alternative structures, while gaining understanding of the particular way a family is organized, can provide important information about the position of the family member compromised by a health problem.

Understanding the structural considerations can shed light on the impact of an illness on both an individual and his or her context. Whereas individual thinking might guide a physician or counselor to describe someone as "a single White female patient who presented with Multiple Schlerosis (MS)," a family-oriented practitioner would be informed of the structure of this patient's family system: "Susan Jones is single parent who has three children under the age of 10. Susan is the sole money earner for the family system and physically very distant from extended family members, so she has little support other than her kids and her job. She describes her family as a 'tight knit group that needs me to function as I have always been functioning.' "

A family counselor with a structural understanding of a family coping with an illness will be naturally led to consider how other people in the patient's context are affected by the disease. For instance, if Susan Jones currently works during the day and takes full responsibility and care of her three children in the evening, the impact of her MS on this family structure will be very different than if she were Rita Smith, married to John who can take over both household and financial responsibilities. Similarly, if a child has a new diagnosis of diabetes and the main parent to oversee the testing and injections is the new stepmother of this child, the dynamics in that system might be very different than if the mother were the child's natural or well-established stepparent.

Constructing a family genogram can be an effective initial method for gathering a better understanding of the structure of the family. The genogram, or family tree, gives a skeletal outline of the family structure and can provide additional family information reflecting various patterns. The structure of the genogram reveals relationships and patterns of functioning that can help clinicians think systemically about events and relationships in their clients' lives and how these are related to patterns of health and illness (McGoldrick & Gerson, 1985).

As one considers the relationships in Susan's family, another structural concept, "cohesion," can help a counselor further understand how this family functions with its illness. *Cohesion* is a term identified by Olson in his Circumplex Model of Family Functioning (Olson, Sprenkle, & Russel, 1979) and by Minuchin (1974) in his Structural Family theory. The term refers to the closeness or level of involvement family members have with one another. In considering the structure of a family, one often assesses the cohesion level of the different family members. Olson's model presents a continuum of closeness for family members to have with one another from those that are high on the cohesion scale (enmeshed) to those who are very low (disengaged). Referring back to Susan Jones, thinking about the level of cohesion can further help a counselor understand this family system. For instance, if Susan's oldest daughter is very closely involved in the physical care of her mother, as well as being very tuned into her emotionally, one might be concerned about the level of cohesion. One may also wonder if, in the midst of Susan and her oldest daughter being very involved with one another, perhaps the younger children feel pushed out toward the edges of disengagement. By being aware of this dimension of the family's functioning with the illness, a counselor may want to address this structural concern.

Minuchin, Rosman, and Baker (1978) described many of the psychosomatic families that they worked with as having very enmeshed relationships, particularly between the mother and the diabetic or anorexic patient. Many family counselors, particularly feminist family counselors, have recently spoken about the term *enmeshment* as being applied to a mother's involvement with a child in a very pejorative way that degrades the relationship and often reflects a misunderstanding of the nature of the relationship (McGoldrick et al., 1989). These feminist family counselors have asked for new language to understand the various levels of involvement between family members; a language with less negative attributions. Nonetheless, being aware of the degree of closeness between family members does have value, particularly in understanding how an illness alters the levels of closeness between each of the family members.

Life-Cycle Considerations

Reuben Hill and Evelyn Duvall were sociologists who developed and wrote about a family life cycle (Duvall, 1977; Hill, 1970). A life-cycle perspective encourages thinking of human growth as an ongoing project that is not limited to just the formative years of childhood. It encourages a systems perspective by incorporating the various impacts of developing over time with ongoing interactions with family and community. Hill's and Duvall's early papers observed that members of the younger, middle, and older generations in the family have their own developmental tasks, and the successful achievement of one person's tasks is dependent on and contributes to the successful achievement by other family members of their appropriate tasks (Carter & McGoldrick, 1980). The concept of the family as a whole having developmental tasks was published by Duvall in 1957; she broke the family life cycle into eight stages, with comcomitant developmental tasks for each stage. Duvall's eight stages address the nodal events related to the comings and goings of family members: (a) marriage, (b) the birth and raising of children, (c) the departure of children from the home (d) retirement, and (e) death. Hill's work underscored the value of considering a three-generational family life cycle and encouraged a broader understanding of the connections between the older and younger generations.

Inclusion of a life-cycle perspective has been incorporated in the work of many family theorists, some with explicit reference to the life-cycle development theories and some not. For example, Bowen's (1978) writings reflected a natural integration of, and an essential appreciation of, the family life cycle. His approach emphasized the value of an early understanding of the three generations of the client.

Carter and McGoldrick (1980) described other family theorists who have made specific reference or explicit use of the theories of family development in their approaches. Carter and McGoldrick further promoted the important value of considering the stage of the life cycle in one's work with a family. This perspective encourages a family counselor to consider the natural emotional challenges that a stage might be presenting to the family, although there may be situations in which a family can be in different stages of the life cycle at the same time. A family with a 15-year-old daughter who is herself a mother of an infant could be straddling two stages of the life cycle at the same time—the family with young children and the family with adolescents. This family would be working on multiple emotional adjustments at concurrent times. A constraint of the traditional life cycle has been its lack of acknowledgment of cultural and class variations. Families of poor, underserved populations rarely have the luxury of the generous time allotments for each stage in the traditional life-cycle models. Similarly, these families rarely have a launching children or empty nest phase.

Carter and McGoldrick (1988) responded to this concern with a second book, *Changing Family Life Cycle*, which described less traditional life-cycle considerations. This book includes several chapters that present alternative life-cycle stages of various races and classes. It is imperative that family counselors consider the family life cycle when looking at the impact that an illness event has on a patient and the family. Questions about how the family is affected at the current stage of the life cycle, as well as what the family can anticipate as problematic in the next phase of the life cycle, can be critical. An example follows.

> Magaly, a 28-year-old Puerto Rican woman, came to talk to her physician about her difficulty in getting to sleep at night and her general wakefulness throughout the sleeping period. The family-oriented physician and family counselor met with Magaly. The physician referred to the genogram prepared by the family counselor and noted that Magaly's long-term boyfriend Enrico had a myocardial infarction (MI), resulting in limited ambulation and limited speech. The family counselor asked Magaly if some of her sleeplessness might not be related to concerns about the boyfriend's recent MI. Magaly began to cry and spoke about her attendant fears: "He provides for us and I don't want my children to be poor. If he can't work, I don't want to put my infant

> in daycare. Enrico and I both feel I should be home with him. The other children are worried and don't like it that they cannot run with their dad in the park."

Because this family is at the stage of the life cycle with young children, it has very different concerns than if it were at the stage of the family launching children. Each stage has its unique developmental tasks and concomitant emotional responses.

Another aspect of life-cycle considerations that is important for those making the transition from individual to family thinking in the medical setting has been well developed by Rolland (1985) in his writings on stages of illness interacting with the stages of the family life cycle. Rolland's model expands the application of life-cycle considerations from the individual patient and the family to the illness also. Rolland developed a three-dimensional matrix that includes a psychosocial typology of chronic illness (i.e., onset, course, outcome, incapacitation) and the time phases of the illness (i.e., crisis, chronic, terminal) with the family's developmental stage. Rolland's framework helps practitioners understand the importance of the interaction between the individual patient, the family stage of the life cycle, and the phases of the illness. Addressing the interaction between each of these components is important when one is working with a family system dealing with a chronic illness. Inserting one's knowledge of a family's life-cycle stage with an understanding of the illness phase can help the family counselor develop more sensitive treatment plans for that family system.

Family Adaptability

A critical quality of family functioning for a family counselor working in a medical context or with families coping with a medical problem is family adaptability: the ability of a family to change its roles and rules to deal with challenges it faces (Olson et al., 1979). Understanding the adjustments all family members make in response to an illness is an important component of a counselor's family assessment and treatment.

> Angela and Derrick Bryant came to see a family counselor on the recommendation of their physician. Angela had been diagnosed with sarcoidosis. The diagnosis helped Angela feel more legitimate in her chronic complaining about aches and pains in her legs as well as intermittent chest pain. The physician treating Angela was concerned about the impact of the diagnosis on Angela and her family. He was concerned that the degree of disability that Angela was experiencing did not match the minimal disabling effects the disease should have

> at this time. The physician was concerned about how Angela and the family system were adapting to this diagnosis and to the disease.
>
> When the family counselor met with Angela and her husband, many important details of the family's adjustment emerged. Since the time of diagnosis, Derrick had quit his job as a mechanic so that he could now be home to do all of the cooking, the majority of the child care, and house cleaning. Derrick's termination of his job was putting enormous financial strain on the family, but Angela repeatedly commented that there was no choice.
>
> Fatigue is a common experience for someone suffering from sarcoidosis. However, in the early stages or in a mild case like Angela's, the degree to which the family system had been altered seemed extreme. There were significant role changes in the family system since Angela had been given the diagnosis. In addition to the responsibilities her husband assumed, it became apparent that he was also home much more than he had been before she had gotten the disease: "Before my wife had this, I have to admit, I stayed out late at nights drinking with my buddies—not every night, but 3–4 times a week. Now that she has been sick, I'm always home."

Although some of the changes, such as her husband being more involved in the family's life, are clearly valuable adjustments for this family, the degree of change in the family system is putting stress on all members. The family's adaptation is fragile. There is great potential for Derrick to become resentful of his multiple roles. Angela, although thankful that her husband is around more, is becoming isolated in the family, and the children are scared and confused. In family counseling with families coping with a chronic or life-threatening illness, the family counselor has access to all members of the family system and can see how members have shifted roles. Sometimes these adjustments are ones that promote healthy family functioning, and sometimes these role adaptations are in fact the focus of family-counseling remedial efforts.

In assessing the family's adaptation to a medical situation, it is important to be on the lookout for a possible "hidden patient." Medalie (1978) talked of the hidden patient as an important concept for those working with a patient with a medical problem. In the Bryant family, one of the children, now neglected while so much attention is on Angela, could become the hidden patient. Derrick, neglecting his hypertension and other health-care needs while attending to his wife and children, could also be identified as a hidden patient.

Adapting to an expected or unexpected death or to a loss (of job, home country, foster placement, adoption, relationship) demands the greatest number of personal resources for a family system.

Learning how the family has coped with former losses and what changes the family has made in response to a present loss are critical for understanding the adaptability of a family system. When dealing with a medical event, a family is often forced to confront losses of (a) life, (b) expectations, (c) function, and (d) dreams. Helping the family members understand the losses, as well as helping them assess their ongoing challenges associated with the various losses, can be a critical role for the family counselor.

Family Rituals

Family counselors have identified family rituals as a valuable consideration when working with families. In many medical situations, an awareness of family rituals can be a very important part of the medical care. An inpatient psychosocial rounds with a family that had twins with ongoing lung complications from their premature births offers a vivid example of the value of addressing family rituals in a medical setting.

> The DeMario family was gathered in the room of the twin 7-month-olds who had repeated hospitalizations due to complications from premature births. The rounds team was made up of a family counselor, attending physician, and two residents from family practice. When the team entered the patient room, they saw the twins in each of the hospital crib beds, another youngster playing on the floor, and two very tired, drained parents. After shaking the parents' hands, one of the residents asked the little girl on the floor her age. She responded by holding up three fingers to indicate she was 3 years old. At that moment, the child's father said, "Cerina, you are 4 now, no longer 3." Cerina emphatically declared: "I am not 4, there has been no birthday party for me so I am still 3!"
>
> After brief discussion with the parents, it became apparent that the parents had been so concerned and consumed with the care of the twin infants that they had not had time to acknowledge Cerina's birthday in any significant manner—not even a cake at home. With the awareness of the importance of family rituals for giving a family a sense of continuity and balance, it was recommended that the family make arrangements to have a special birthday party for Cerina. Perhaps the lack of celebration of a 4-year-old's birthday may not seem significant when compared with the seriousness of the hospitalizations of the infant twins However, it is significant in reflecting how much the family system has been altered by not attending to rituals that help give family members a sense of group identity and historical connectedness. At the next visit with the family during inpatient rounds the following week, they happily announced that over the weekend they had a party for Cerina. The family commented that it was helpful for all of them to resume some familiar family ritual (a

birthday party). They reported that it was wonderful to have some hours devoted to celebration and to Cerina. They spontaneously acknowledged that the party helped them feel back on track with the family.

Imber-Black (1988) described three categories of rituals: (a) family celebrations, (b) family traditions, and (c) patterned day-to-day interactions. Celebrations are ways that a family publically acknowledges a major life-cycle event as well as brings support to the family by gathering outsiders to come and help the family celebrate an important event. Both happy and sad events belong in this category: (a) baptisms, (b) bar and bas mitzvahs, (c) weddings, (d) major anniversaries, and (e) funerals. Sometimes families are uncertain as to how to mark a powerful idiosyncratic life-cycle event such as suicide, divorce, or placement of a child in a long-term residential setting. Exploring with a family the difficult decisions of going ahead with a long-planned wedding soon after the death of a father from cancer or the process a family might employ to mark the difficult death of a daughter who had recently committed suicide is an important role for a family counselor. A family counselor can discover that helping a family find a meaningful ritual that both acknowledges the event and brings support to the family going through the difficult situation is a creative and healing venture.

Another part of an evaluation of how a family is coping with an acute or chronic illness should include inquiry about the family's traditions and patterned day-to-day interactions. Have they ignored important life-cycle occasions in the midst of providing care for a chronically ill member? Have they stopped their family tradition of an annual family reunion since the onset of a chronic illness in one family member? Have they stopped their regular habit of reading stories at night to the 4-year-old since the diagnosis of cystic fibrosis in their younger child?

Family Beliefs and Explanatory Models

Families hold beliefs and have explanatory models that inform their behavior in response to an illness or other medical event. Being aware of both the patient and the family's belief about how and why they became ill, what and who will help them get better, and the like is essential for anyone working with a family dealing with a medical concern. Family counselors can benefit from the writings of anthropologists and sociologists interested in beliefs and explanatory models. Kleinman (1988) stressed the value of understanding the subjective world of the patient's thoughts and feelings in a clinical interaction. Kleinman, Eisenberg, and Good (1978) suggested eight open-ended questions that can be used to elicit patients' explanatory model or illness models. Good and Good (1981) recommended specific questions that elicit interactional patterns related to the meaning of the illness and behavior assumed around the illness. Because the patient's illness most often occurs in a family context, it is important that the elicitation of explanatory models and beliefs be gathered from all family members. A recently published study explored whether there were differences between patient and family explanatory models (Jaber, Steinhardt, & Trilling, 1991). The results of this study showed that differences in opinion between patients and their families are quite common and add relevant complexity to illness and treatment behavior. The importance of exploring the families' beliefs has been emphasized to ensure a successful negotiation of a plan of care.

Patterson (1989) investigated (a) the relationship between couples' beliefs and attributions about the causes and consequences of coronary artery disease and treatment, (b) the patient and spouse's response, and (c) ultimately their adaptation to either by-pass or angioplasty. She found that families have a set of core beliefs called the "family schema" about themselves in relationship to each other and about their family in relationship to the community and the world. Patterson believed that this schema provides a template for approaching and solving day-to-day problems, especially situations characterized by ambiguity, as well as offering continuity in time and across relationships for the cognitive and affective dimensions of family life. Understanding a family's beliefs about an illness event, process, and etiology is of fundamental significance for anyone working as a family counselor with medically involved family systems. An example helps illuminate this point.

> Marina had been hospitalized for an exacerbation of her asthma. When doing psychosocial rounds on a family-practice service, the family counselor gathered Marina's family genogram. Marina was currently living with her mother and her two sons, Ricardo, 4, and Jorge, 3. When Marina was initially asked how this most recent exacerbation of her asthma occurred, she said she really did not know. Then as Marina elaborated about her mother, she commented that her mother had always been very protective of her because she was the "sick" child in the family. Marina said she always hated how overprotective her mother was. Currently, Marina's mother was in Puerto Rico visiting family and was due to come back to Cleveland on the day Marina was admitted to the hospital. Toward the end of the interview, the counselor asked Marina to describe her mother. Marina thought for a moment and then started giggling. When asked what was so funny, Marina said, "I started to say that my mother is the kind of woman

> who gives you no room to breathe." Marina followed this startling insight with, "I guess I do know what caused this bout of my asthma. While my mother has been in Puerto Rico, I had an affair that I know she wouldn't approve of. I was terrified to face her and I think I brought this whole illness on this time."

Gaining this understanding of the patient's explanation and understanding of her mother's beliefs helped determine how treatment would proceed in the future with this patient. A plan was made for Marina's physician and the family counselor to meet with Marina and her mother to discuss some issues around (a) personal boundaries, (b) developmental changes, and (c) management of her illness.

Ethnicity and the Family System

A patient's ethnic background dictates much of the family's beliefs and customs. When treating a family in the medical setting, an understanding of the ethnic influences can facilitate a good working relationship with a patient. Gaining an understanding of the ethnic influences on the patient naturally leads one to the family system. Families' beliefs about the etiology and management of many health issues are greatly influenced by their ethnic background. An exploration of these ethnic influences is invaluable. Often what may be termed as *resistance* or *noncompliance* by the patient or family may be resolved through greater understanding of those beliefs based on their cultural heritage.

> Mr. Hrusak, a recent Russian immigrant, had been recommended to be put on the heart transplant list with the discovery of his severe cardiomyopathy (i.e., enlarged, poorly functioning heart). He was very adamant that he did not want the transplant, telling the interpreter, "Nyet, Nyet, Nyet." On a home visit to the Hrusak home, the family counselor and physician decided to re-open the transplant discussion with Mr. Hrusak and his wife. The question was posed as one of curiosity about Mr. Hrusak's resistance to having the option of a heart transplant. Mrs. Hrusak responded, "I'll tell you why. In Russia, we heard that the only way they get a heart in the United States for a transplant is by going around and killing someone. That would be a bad heart then—we don't want anything to do with that." After an alternative description of how a heart is acquired for a transplant was described, Mr. Hrusak said he would be willing to explore the possibility. However, Mrs. Hrusak stated, "My religion (Pentacostal) teaches me to have more faith in God than in doctors so I am not so sure I want this." The understanding of Mr. Hrusak's belief allowed the physician to present an alternative explanation that Mr. Hrusak could consider. Mrs. Hrusak's belief is equally important for the physician to understand. Knowing that religious beliefs are the dominant

ones for her, the physician might be well advised to get a clergy colleague involved if any further discussion about the transplant is to take place. Without appreciation of these ethnic influences, the family counselor and physician would have had trouble forming a working alliance with the family. The inquiry into the family's ethnic influences not only helped guide the therapeutic process but ensured a fascinating intercultural education for these family-oriented practitioners.

Family Stories

Family stories are a rich resource for anyone involved with a family coping with a medical illness. Family counselors are increasingly seeing the use of narrative and storytelling as a wonderful resource for learning more about, as well as treating, the family. Kleinman (1988) extolled the skills of the anthropologists who glean important narratives that expose patients' illness beliefs, customs, and solutions. Because of physicians' perceptions of themselves as needing to be careful to get the biomedical story, they can often miss some of the other rich details of a patient's illness story that teaches about the family of the patient (Cole-Kelly, 1992). A family counselor needs to be tuned to the multiple family stories that are important to each member of the family as they cope with a difficult medical situation.

Epson (1991) described using stories as a method to help individuals and families change their understanding of important life events. The family counselor creates new narratives or stories that give patients and their families alternatives to coping with difficult situations. Anderson and Goolishian (1988) contributed much to this area of treatment with their interest in the language people use to talk about their problems. They advocated helping families learn new ways of talking about their problems—new language that helps them see and experience their problems in less stuck or dead-end ways. The therapeutic process is promoted through conversation in which new stories are created that help remove fixed or frozen stances, behaviors, or beliefs. Demonstrating curiosity about a family's illness story, as well as stories about the system before an illness struck, can result in rewarding interactions between the family and the counselor, leading to beneficial changes. The creative uses of alternative narratives and stories that emphasize strengths and opportunities can be a valuable resource for family counselors working with families coping with medical situations.

Family Strengths

Looking for and emphasizing strengths in family treatment is often a sharp contrast to the pathologizing approach many expect from a therapeutic encounter. Particularly in a medical setting where pathology is often the focus, an emphasis on strengths can be an energizing and expanding experience for a family system. A recent encounter illustrates this point.

> The Smith family was composed of Bill, 25, Rena, 26, Lucia, 8, and Ricky, 3. Recently, Bill's renal disease had worsened, requiring nightly dialysis at home. The parents had made the request to meet with their doctor and the family counselor to address their concerns about their daughter. The parents were encouraged to bring the daughter and their son with them for the session. The parents said they were worried that something might be wrong with their daughter. She constantly asked questions about her father's kidney disease; sometimes she had trouble getting to sleep as she often called her mother or father into her room to ask them questions.
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> During the family session, both parents were physically and emotionally attentive to Lucia and her brother. As discussion ensued, it was clear that Lucia was doing well in school, getting along well with peers and her family members, eating well, and, although occasionally having trouble initially getting to sleep, was sleeping soundly through the night. Neither parent felt she could be described as depressed, but both parents were concerned that perhaps something was wrong because she asked so many questions about her father's kidney disease. After hearing how well Lucia was functioning in school and with peers, combined with the ease in which the family members interacted in the family session, the family counselor highlighted how it was a reflection of the family's strength that Lucia could ask so many questions.
>
> Any child would have questions, worries, and confusion when a disease takes such a dominant place in a family's life. This family had created an environment in which Lucia could ask questions and have confidence that she would be heard and receive a response. When this question–response process was put in a positive light, Bill said, "You are so right now that I think of it. My parents' motto was: 'Children should talk when the chickens pee' and have you ever seen a chicken pee? I haven't. As a child in my family, we never could talk except when spoken to. I now realize that these kids do feel like they can talk. I never did as a kid. That's probably why it seemed so strange to me when she just kept questioning and questioning." At the end of the session, both parents stated how they felt relieved and bolstered to know that what they were doing was good.

A number of family-counseling models emphasize family strengths over family vulnerabilities, and family resiliency over family failures. DeShazer's (1988) Solution-Focused Model is one in which patients' resources (and those of the family/larger system) are emphasized and used to construct a solution by talking about times when the problem is not there, a positive picture of the future without the problem and concrete achievable goals. This discussion elicits strengths and promotes a step-by-step procedure by which the patient and family construct their own solution.

The consideration of each of these core concepts provides a natural bridge for the counselor making the transition from individual to family thinking. Each concept effortlessly draws the counselor into thinking about the patient's medical event in his or her family context. Counselors will find that extending the inquiry and consideration of the impact of the medical event on the family system and the impact of the family system on the individual with the health concern results in a rewarding experience for all participants: the family counselor, the family's physician, and patients and their families.

The Settings and Situations

There are multiple settings and situations in which one can practice a family orientation with clients experiencing medical issues. The settings include: (a) outpatient treatment (teaching hospital clinic, private medical clinic, private practice), (b) homebound care, (c) inpatient hospital settings, (d) nursing home facilities, and (e) residential care placements. There are multiple arrangements possible for family meetings as well. A family could be seen either individually by the family counselor, by a team composed of a family counselor and medical trainees, or by a collaborative team of family counselor, primary-care physician, and/or nurse (Glenn, 1985; Hepworth, Gavazzi, Adlin, & Miller, 1988; McDaniel, Campbell, & Seaburn, 1990). The family counselor can decide which arrangement will work most effectively with the specific setting of the encounter and with the specific medical event.

The range of situations in medicine to which a family counselor can offer his or her expertise is broad. Situations include families (a) dealing with a chronically ill member, (b) adjusting to a difficult diagnosis, (c) coping with an acute medical event such as a family member's myocardial infarction, and (d) adjusting to an expected or unexpected death or other unexpected medical loss (e.g., eyesight, limb, lung). A family may be referred to a family counselor because the medical professional cannot find any physical explanation for the somatic complaint of an individual. These situations, which are often the most perplexing and resistant to intervention, demand delicate collaboration between the medical professionals and the family counselor (Doherty & Baird, 1983; McDaniel et al., 1990).

A family counselor can extend systems concepts to gain better understanding of the functioning of the patient in his or her family as well as the context of care. Each system has its own (a) structure, (b) beliefs, (c) rituals, (d) modes of adaptation, (e) ethnic influences, (f) stories, (g) life cycle, and (h) strengths. Applying systems knowledge to these environments may be helpful to a family's adjustment to that situation. Wynne, McDaniel, and Weber's (1986) *Systems Consultation* explored the multiple environments in which one can utilize family-systems knowledge to address systems problems or conflicts.

Systems concepts have also been usefully applied to the interaction process between the physician and the patient/family. Doherty and Baird (1983) demonstrated how this system is vulnerable to the same dynamics that a family system experiences. Analyzing the doctor–patient/family interaction with a systemic orientation can lead to a better understanding of problems around noncompliance and resistance, as well as help health-care providers understand the causes of compliance and cooperation.

Evolving Developments and Future Directions

The 1980s gave birth to the integration of family-systems thinking into the field of family medicine. It also was the decade in which the field of family counseling developed its most solid identity and firm position. The disciplines of both family medicine and family counseling have created models for working together and pursuing collaborative opportunities. Special projects such as the Chronic Illness Project at the Ackerman Institute have been developed using family-counseling techniques with certain chronic illnesses (Penn, 1983; Walker, 1991). Additionally, family counselors are expanding their work as group leaders of multiple family psychoeducational groups with families coping with various chronic illnesses (Gonzalez, Steinglass, & Reiss, 1988). The psychoeducational model emphasizes patients' and families' strengths and their own abilities to cope with chronic illness. In the psychoeducational groups, families are given the information and skills deemed helpful for them to cope with chronic illness, as well as receive emotional support and evaluative feedback as to how they are adjusting. An eight-session program incorporating both psychoeducation and multiple family-group process is a treatment focus for a broad range of chronic illnesses at George Washington University Medical Center (Gonzalez et al., 1988).

Family-systems thinkers are expanding their collaborative efforts with multiple primary-care specialties. The Academy on the Doctor and the Patient in Internal and General Medicine, which offers workshops on medical interviewing, has been working collaboratively the last 2 years with family counselors and family-systems-trained family physicians. An outgrowth of this type of collaborative effort has been a formal course in medical family interviewing co-sponsored by the Departments of Family Medicine and Internal medicine at the University of Rochester.

Counselors interested in working in the health-care context should be familiar with the growing body of research on the family's impact on health. Campbell (1986) wrote an exhaustive review of this research for a National Institute of Mental Health series. This review includes an annotated bibliography of the multiple research papers on the family's impact on health. Doherty and Campbell's (1988) book on families and health reviewed (a) families' responses to acute and chronic illness, (b) their vulnerability to illness, and (c) ways to implement a family approach in treating these conditions.

Counselors interested in working in a medical context or with patients suffering from medical problems can find rich opportunities for rewarding and challenging family work. However, there is one word of caution to those intending to work with medically compromised patients and their families: It is important that anyone working in the context of medicine remain alert to signs of burnout, depression, or indifference. It can be very difficult and demoralizing to work with situations that involve chronic illnesses and terminal situations. Family counselors who work with a steady population of patients with illnesses need to find colleagues with whom they can process their own feelings. Combining work with families coping with an illness and families dealing with other, less stressful challenges such as remarriage, relocation, and school-adjustment problems can be helpful.

The multiple stories, characters, histories, and idiosyncracies that come with every family coping with a medical event easily engage a curious, committed counselor. Anyone interested in working with families can find a field filled with excellent literature and endless opportunities. The involvement with families coping with a medical event can enhance professional satisfaction and ensure professional enthusiasm.

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10

Playing with Contextual Complexity: Relational Consultation with Family Businesses

Douglas G. Flemons
Patricia M. Cole
Nova University

Over the course of 10 months in the late 1970s, two important figures in the field of family counseling, Luigi Boscolo and Gianfranco Cecchin (the Milan Associates), worked with Irving Borwick (a corporate director at ITT) and Bruce Reed (from the Grubb Institute in London) to investigate the applicability of Milan systemic family counseling concepts and techniques to business organizations. The group concluded that there was no simple translation between the worlds of family counseling and organizational consulting; they considered their work with management teams unsuccessful and they disbanded (Borwick, 1986). Borwick came away from his collaboration with the Milan Associates with the realization that families and business organizations are significantly different systems, and that counselors "who enter into business organizations must begin to develop new maps and new roles" (p. 439).

Therapeutic consultation with families and organizational consultation with businesses are each complex processes requiring different sets of expertise and experience. What then are family counselors to do when they are consulting with a system that is simultaneously a family and a business? Along with a variety of other "helpers," family counselors are providing an increasing amount of consultation for family businesses (Robichaux, 1990). But do we have the necessary maps and the necessary tools to responsibly offer assistance? This chapter charts a way of thinking about and working with these systems that aims at respecting the integrity of both family and business and the complexity of the relationship between them. It presents a model for understanding the sorts of confusions and concerns that arise when family and business become knotted in emotionally distressing and/or financially troubling ways, and it suggests some ideas for how to help with the process of untangling. It begins with a brief discussion of the place of family businesses in the American economy, proceeds with a brief philosophical justification for taking a relational stance to understanding, and then uses this discussion to begin the process of constructing a relational approach to family-business consultation.

Family Businesses

Contrary to the stereotype, family businesses are not just small "mom and pop" operations. Not only have familial relationships become much more varied, with daughters and wives taking positions of responsibility that only a few years ago were strictly the domain of fathers and sons, but the market share of the American corporate pie that family businesses enjoy is truly staggering. Following Rosenblatt, de Mik, Anderson, and Johnson (1985), if we define a family business as "any business in which majority ownership or control lies within a single family and in which two or more family members are or at some time were directly involved in the business" (p. 4), then it is possible to assert that more than 90% of America's million businesses are family controlled, accounting for approximately 40% of the gross national product (GNP; Galagan, 1990).

In the last 5 years, more attention than usual has been directed toward family business (Dyer, 1986; Jaffee, 1990; Rosenblatt et al., 1985). For the first time, large numbers of family-business founders simultaneously face retirement, and succession issues take on great importance for the economic future of the companies and the economy to which they contribute. The roots of the present-day situation can be traced back to post-World War II, when an influx of returning GIs started their own businesses. Presently, as these founders prepare for retirement, their enterprises face extinction unless a smooth transition can be made from first generation to second.

An example of a difficult transition involves a father who, on paper, has turned over the business to his daughter, but wishes to remain involved in the day-to-day operations. If not delicately handled, this type of situation can quickly devolve into a leadership tug of war; in the wake of such a struggle, the daughter might choose to leave the company entirely. Such succession issues, although not the focus of this chapter, highlight an important point: If it is true, as Borwick (1986) claimed, that businesses and families are very different sorts of organizations, then it is equally true that family businesses are not a simple amalgamation of the two. Business relationships are different by virtue of being among family members, and family relationships must somehow accommodate business-related issues.

Thinking and Working Relationally

Family counselors, particularly those influenced by the cybernetic ideas of Bateson (1972), have long contended that an individual's problems are best understood in the context of his or her family relationships (e.g., Haley, 1963; Palazzoli, Boscolo, Cecchin, & Prata, 1978; Watzlawick, Weakland, & Fisch, 1974). For example, a man may describe his feelings of depression in intrapsychic terms, but his psychophysiological experience and the way he understands and "shows" it is part of a communicational web of relationships that he participates in creating and maintaining. Thus, it makes good contextual sense to consider the man's symptoms in relation to the beliefs, attitudes, and responsive actions of his family members. It is in this sphere, in the relations between family members, that family counselors typically direct their suggestions for change. Rather than attempting to help the man personally explore the historical causes of his depression, a family counselor would play with ways in which the interactive patterns involving the man, his defined depression, and his family could in some way be altered.

The family-business consultative model offered here uses such contextual assumptions as a template for organizing a relational approach to working with clients. However, the approach is more directly influenced by Bateson's philosophical insights than by the idiosyncratic ways in which they have been adopted and adapted by particular family-counseling theorists and clinicians. Following Boscolo and Cecchin (Borwick, 1986), we believe that family-counseling models are too context specific to be directly applicable to other organizations. However, Bateson's ideas are abstract enough to be differentially adaptable to any system of relationships.

A more in-depth philosophical discussion of the therapeutic implications of Bateson's ideas, and their elucidation in terms of family-business consultation, have been offered elsewhere (Flemons, 1991; Flemons & Cole, 1992). Our intent here is focused on describing the particular way in which ideas about relationships can be used to organize a consultant's work with clients. Still, it is important to make brief mention of the philosophical justification for taking a relational stance.

There are two primary ways to support the contextual claim that meaning resides in relationship, both of which have to do with the business of knowing. The first concerns the nature of perception; the second concerns the nature of language. According to Bateson (1972, 1979), we perceive relationships not things: "In the world of ideas, it takes a *relationship*, either between two parts or between a part at time 1 and the same part at time 2 to activate some third component which we may call the *receiver*. What the receiver (e.g., a sensory end organ) responds to is a *difference* or a change" (1979, p. 106). Language, too, is relationally structured. Norris (1987) considered it "a cardinal precept of modern (structural) linguistics that signs don't have meaning in and of themselves, but by virtue of their occupying a distinctive place within the systematic network of contrasts and differences which make up any given language" (p. 15). Given that knowing and understanding are shaped by perception and language, it is clear that no known thing exists in isolation, and that meaning is contextually determined: "This" makes sense only in relation to "that."

The practical implications of such an understanding reverberate throughout the consultative process. The consultant's attention never settles on an isolated person, symptom, idea, problem, or solution, but constantly questions how each derived "piece" of information fits with or connects to others. The overarching question informing this process has to do with how family and business contexts are each separately and jointly defined and related.

The Relationship Between Family and Business

For the most part, theorists have conceptualized the sorts of problems that can arise in family businesses in terms of the incompatibility between family and business roles. Constructs such as "role conflict" (Salganicoff, 1990), "role carryover" (Rosenblatt et al., 1985), and "role confusion" (Freudenberger, Freedheim, & Kurtz, 1989) have been offered as means to explain what happens, for example, when a boss acts like a father or a father a boss. The notion of role allows one to describe the different relationship demands of a family and a business from the perspective of each of the individual participants. A father (a role that is defined in relation to the role of child) is generally expected to act differently than a boss (a role defined in relation to an employee). When one role overlaps with another, contextual confusion can reign supreme. What is a comptroller to do when the CEO, her father, handles her criticisms of his decisions by telling her that she sounds too much like her mother? Is it possible for a son to ask advice from his father about his marital problems when he is in competition with his sister for vice president in charge of marketing? Will the father's empathy yield to worry about whether his son is capable of handling pressure?

Imagine a father and a son who, as partners in a business venture, are unable to agree on an important contract. Their stalemate might be traceable to what could be interpreted as a clash of roles—a partner who cannot stop being a father when he is trying to convince his associate to change his mind, or a son who cannot stop being a partner with his father during weekend get-togethers. How is a business partner to react when his associate acts like (and is, in fact) his father? If he responds as a son, he undermines his position as co-author of their business fate; if he responds as a colleague, he risks insulting his father and ignoring his filial responsibilities. Similarly, how is a father to react when his son uses Sunday dinner to demonstrate, in front of the extended family, his brash independence and lack of respect? If, as a father, he admonishes the son's impertinence in front of everyone, he risks embarrassing him and further entrenching the cocky attitude that has been so predominate at work; if he responds simply as a business partner, the father publicly relinquishes his position as respected patriarch of the family.

The role dilemmas each man faces make clear how difficult, indeed impossible, it is for family business members to follow simplistic, albeit well-intentioned formulas for improving relations. It would not be uncommon for a consultant confronted with such a scenario to counsel the father and son to each strive to keep their family and business roles clearly distinct. But such advice reveals two mistaken premises about relational phenomena. First, it assumes that roles are somehow formed within the individual, rather than constituted in relationship to the verbally and nonverbally communicated stance(s) of the other person(s) in the interaction. Second, it assumes that such relational phenomena are indeed separable. Each premise is discussed next, and the consultative implications of a different understanding are outlined.

Mistaken Premise 1: Roles Exist with Individuals

Roles can be considered shorthand descriptions of interactions because they define positions taken in complementary relationships. A child needs a parent to be a child; to be a boss, one needs employees. To help in not losing such a relational understanding of clients' roles, a consultant would do well to attend primarily to the interactions to which roles refer, the patterns of behavior that characterize the family context, the patterns that exemplify the business context, and the patterns that emerge as a function of the family-business interface.

Such an orientation brings forth a number of interesting context-sensitive ideas to explore. In reference to the father–son relationship described previously, one might ask some of the following questions: Are there aspects of the men's familial tie that are important to preserve in their business discussions? Is the son trying too hard not to be his father's son, thereby impelling dad to "put him in his place?" Where do they have their business meetings? Are the two of them relating at work as they did when the son was growing up? If so, is it helpful? If not, why not? Who pays for lunch? What do they call each other at work? What would happen if the two men purposefully set out to discuss the contract issue twice over, once on the same long walk in the botanical gardens they used to take together when the son was a youngster and again in the boardroom, complete with white shirts and first names? With such an orientation to consultation, one searches for ways in which the contextual complexity of family-business relationships can serve as a resource for, rather than an impediment to, a resolution of their stalemate.

Different contexts, such as a family and a business, can be distinguished in terms of the set of relational rules or expectations of which they are composed. Contextual rules can be understood as redundant patterns of interaction between individuals, as "agreements" or "formulas" that "prescribe and limit . . . individuals' behaviors over a wide variety of *content* areas, organizing their interaction into a reasonably stable system" (Jackson, 1965, p. 9). Certain interactions are expected, and certain interactions are not expected. Rules and expectations change when contexts change, even if the individuals involved are the same in each case.

The confusions and misunderstandings usually described as accompanying role overlap can thus be explained in terms of what happens when expectations do not change from one context to the next. For illustration, consider the case of a husband and wife whose marriage and joint business are in jeopardy. Some years before, when their two children were young, the wife had begun selling diet and beauty products out of their home. Her husband, who had not wanted her working at all, put up with "this little hobby of hers" because it "wasn't a real job" and he could "keep tabs on her." But the wife was effective in sales and a hard worker; before too long she had other women working for her and, over time, she established a significant distribution network for the products. To her husband's chagrin, she began making more money than he. He took a deep breath, quit his job, and joined his wife in her growing enterprise. The marriage had been organized patriarchically—the husband had the final word on most issues. However, the business was started and developed by the wife, and, although she spoke of her husband as a partner, it was clear that he was at best an equal on her terms, despite his best efforts to have it otherwise. Needless to say, there was much contextual confusion where family and business overlapped because many of the implicit rules and expectations—such as how decisions were to be made and who was to make them—in each context contradicted those in the other. The couple fought incessantly over issues, such as the selling of their house, that had implications for both the family and the business.

Again, a consultant who misconstrues roles as individually defined characteristics would probably suggest that the husband and wife keep their family and business roles clear and distinct. This would be an excellent suggestion if it were possible to do. However, as with all good advice, it is much easier said than done. To understand why this is the case, it is helpful to move to a discussion of the second mistaken premise.

Mistaken Premise 2: Relational Phenomena Are Separable

If, as Bateson proposed, the informational world of perception and language we inhabit is relationally structured, then any attempted marking of a distinction (e.g., asserting and striving to ensure that one's "father role" does *not* contaminate one's "boss role") is a relational act. That is, separations connect. A good example of such relational understanding can be found in Bowen's (1985) insight that forcibly and angrily cutting off contact with one's parents and siblings is not an effective means of emotionally divorcing from them. The attempted separation forges a connection, even across physical distance: "The person who runs away from home is as emotionally attached as the one who says at home.... He runs away kidding himself that he is achieving 'independence' " (p. 535). Similarly, people's most concerted attempts to eradicate some despised aspect of themselves, such as a smoking or drinking habit, unwanted thoughts or dreams, eating too much, panic attacks, and so on, can sometimes have the paradoxical effect of tying them that much tighter to that from which they wish to separate (Flemons, 1991). In the realm of human communication, where issues of selfhood, marriage, and social and business relationships are necessarily managed, there is no such thing as pure separation.[1] Any boundary that successfully distinguishes "A" from "B" simultaneously ensures that each is defined in relation to the other. Thus, to bring the discussion back to the topic at hand, all anxious attempts to sever family and business roles will necessarily fail to do so. This can cause problems, but it can also suggest solutions. The challenge for consultants becomes not how to get clients to separate this role from that, but how to help them discover and invent the ways in which the relationship between the contexts they participate in can be both separated and connected in interesting and creative ways.

For example, if the inescapable association and dissociation of contexts is applied to the marriage/business difficulties discussed previously, several ideas emerge for establishing a helpful consultative orientation. The couple may think of their marriage as one in which the husband is the head, but their relationship in the business challenges that easy assumption. If he has already exhibited the strength and flexibility necessary to appreciate his wife's ability to create a business opportunity for both of them, in what other areas of their marriage has he discovered and shown similar qualities? How can he use his patriarchal proclivities to help him demand that his wife develop her independent spirit in both the business and the family? How can the wife independently find ways to access her husband's experience and ideas? How can they keep family and business separate in ways that enhance their interdependence?

Each question asked previously can help move the consultant and family in the direction of discovering resources—resources that can be mined from either family or business context and applied as is or in some transformed fashion to the same or the other context.[2] The following case example illustrates this approach.

Consulting with a Family Business

A woman in her late 40s asked for advice in handling problems with her 70-year-old mother over a jointly run dry cleaning business.

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[1] Actually, this is not quite true. Entropy, or the scattering of pattern, is the one kind of separation that is not also a connection. See Flemons (1991).

[2] This has some obvious associations with the "solution-focused" work of de Shazer (1982, 1985) and O'Hanlon and Weiner-Davis (1989).

The daughter, who wanted to discuss the situation without her mother present, complained that her mother (a) did not give her enough responsibility, (b) treated her like a child, (c) and left their job descriptions undefined.

When the consultant explored positive interactions between mother and daughter outside of the business, the daughter identified several things. The most striking of these was their shared belief that women must put themselves and their families first. The consultant then asked questions such as the following to determine how this could be used as a resource in the business.

1. How much do you and your mother agree on the need for a woman to put herself and her family first?
2. How does that translate into your working relationship?
3. How flexible is your working interaction with your mother regarding personal time for sick leave, vacation time, and child care?
4. When does this flexibility and understanding of a mother–daughter relationship work for you in the business?

These questions helped the woman connect the positive interactions of flexibility inside and outside the business. By doing so, she moved toward realizing that undefined or flexible job responsibilities (one of her original complaints) allowed her the freedom of missing work for family and personal time. Once home and work could be connected in such a way that one did not simply undermine the other, the daughter was able to begin building a more positive working relationship with her mother.

This example illustrates some of the benefits of thinking relationally, of accounting for the necessary connections between family and business, and using them to help alter stuck interactions. Such a perspective allows for great flexibility of response to the various conundrums faced by family-business clients.

A relational approach to consultation can perhaps be described best by offering some of the questions that can be used to organize the consultant's work with his or her clients. These are not questions that would be asked directly of the clients, but rather of oneself, to shape the direction and nature of the consulting process:

- What are the rules of interaction in the family?
- What are the rules of interaction in the business?
- In what ways are family and business kept separate? How helpful are these separations? In what ways do attempted separations create unintended connections? For example, are brother's attempts to "just be the boss" at work making his sister

all the more aware that he is "just her little brother?" Who monitors and maintains the boundaries (between family and business)?

- In what new ways can the two contexts be separated? (A common tact taken is for family members to call each other by their given names at work: has this or other similar ideas been tried?)
- In what ways are family and business kept connected? How helpful are these connections? In what ways do attempted connections create unintended separations? For instance, is husband pushing his wife away when he talks shop on the weekends? Who stirs family issues into the business, and vice versa?
- In what ways should difficulties at work be understood as having nothing to do with family issues, and vice versa? Despite this, can the necessary connections between the two contexts be used as a resource to help resolve a difficulty in one or the other? That is, in what ways can successful interactions at work be utilized at home, and vice versa?

Summary

Members of family businesses are rather like any specialized group of individuals: They tend to trust those who have had similar experience. For those of us who belong to family-business enterprises, credibility is more easily won; for those of us who do not come with that particular passkey in hand, we would do well to follow Borwick's (1986) advice: to acquaint ourselves with "the territory of the business world" (p. 439), whether through research, or training and education opportunities. This, coupled with a consultation map such as the one outlined here, can provide a grounded, flexible orientation to a most fascinating and complex world of family-business relationships.

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Family Counseling in a Private-Practice Setting: An Interview with Frederick Brewster

Charles H. Huber
New Mexico State University

Frederick Brewster, a family counselor in private practice in Silver Spring, Maryland, is interviewed in a 5-year follow-up to his 1987 (January–February) *Family Therapy Networker* article (with Kitty Montie) entitled "A Double Life," in which he and Ms. Montie expressed their views on what family counselors really do in a private-practice setting. In the following interview, he expounds on these earlier expressed views; he offers his experiences, recommendations, and predictions relative to doing family counseling in private practice.

Huber: Five years ago you and Kitty Montie wrote a superb article for the *Family Therapy Networker* entitled "A Double Life," in which you both expressed your views on what family counselors really do in a private-practice setting. In that article, you described a social worker whose training in family counseling profoundly changed the way she approached her work. You also noted, however, there was a catch: She was unprepared for the adjustment that her new way of doing counseling would force her to make in private practice. Would you say this is still the case 5 years later?

Brewster: I certainly would, especially with certain models of family counseling. Take, for instance, the popular brief or short-term approaches. I know some counselors who do short-term family counseling and are known as short-term counselors. They have a very wide referral base. They are successful as family counselors in private practice, but they work very hard and have a steady flow of families passing through. It can be done, but I think you have to work very hard with referral sources and gain a reputation for doing short-term counseling.

Huber: What about longer term approaches to family counseling? How do you see that working in a private-practice setting?

Brewster: The model that best fits in private practice in my experience is the Bowen Family-Systems model. With that model, you call every person that walks in "a family." It is an inherently long-term model. That's very amenable to private practice. It does, however, take quite a time for a counselor to understand the model. You know what they say, "You sit with it for 10 years and then you get to know what it's about."

Huber: In line with that, then, do you believe that family-counseling training has evolved adequately to prepare counselors intending to enter private practice? It sounds from the statement you just made, perhaps not in the short term anyway.

Brewster: I basically believe that family counseling per se isn't particularly amenable to private practice. I think that if you are a family counselor and desire to enter private practice, you need to make some switches in your thinking in order to survive.

Huber: Do you think people are being trained to do that?

Brewster: No, I don't. I think there is a lot of talk about theory and technique, but what professionals do in their offices is very different from what they typically learn in their graduate training or hear at conferences. I think that the talk Dennis O'Brien and I gave at the Networker Symposium in Washington, DC, on family counseling in private practice drew a lot of people who wanted to talk about what they were really doing as opposed to what they might read about in books and journals.

Huber: So too much of family-counseling training in your opinion is theory and technique but not enough of the practical side. Someone considering a private practice in family counseling had better be prepared for the pragmatics that he or she must deal with.

Brewster: Yes, for sure.

Huber: In your 1987 article, you proposed that family-counseling private practice can sometimes feel like and I'll quote you, "promoting a product that customers aren't interested in buying." This sounds like one of those pragmatics. What might have been some of your experiences that led to suggesting that?

Brewster: Well, I just think to sit in a room with a family and talk about difficult issues isn't a comfortable experience for anyone. In a family in which the parents have been recently separated, for example, family members need to talk about how it is to be living in two houses and how it is to carry suitcases to school and the like. It would be easier for everyone to have an individual counselor. I think that it's just easier for family members and counselors, too, to pursue such issues in individual counseling; not necessarily more effective or appropriate, just more comfortable.

Huber: So the ease of talking to a counselor one on one as opposed to being helped to talk with one's family members makes family counseling a "hard sell."

Brewster: Right. I think that most people's emotional pull is to think individually. Even in doing Bowen Family-Systems counseling, without all involved family members in the room, it is difficult to think of one's individual process in the context of one's family. It means that we are subject to forces outside ourselves.

Huber: What have been some of the ways you personally have found to promote the product of family counseling?

Brewster: I've changed a lot since I went into private practice. When I first went into private practice, I strongly emphasized the importance of all family members convening and I lost a fair amount of clients. Now I begin where the family is. I ask how they want to come in and what they want. I see them the way they want to be seen and then gradually—and where appropriate—begin to introduce family-systems concepts.

Huber: So progressively, in one way or another, you try to move toward a family-counseling focus.

Brewster: Yes. Some families actually call up and request a family focus, but that is still relatively rare.

Huber: Those families that do call up requesting a family focus: Is it easy for them, or is it difficult for them to stay with that focus once they realize what it involves?

Brewster: I don't think it's ever easy because it means working on important relationships. I see some families only three or four times a year because that's when they all gather together. They call when they have specific issues to address and a lot of work gets done.

Huber: So even with some families who might specifically request family counseling, you still need to progressively sell them on the approach if they are not clear in what they want.

Brewster: Yes. I think that you need to teach them about systems thinking, about how to manage anxiety and be less reactive, and how to stay calm. I think now I do more interventions that focus on helping people just stay calm, be thoughtful about what's going on. Rarely do I turn up the flames on a crisis.

Huber: It sounds like that is not where you started originally.

Brewster: I started out with the Bowen Family-Systems model and it's one of my reference points. My first job was in crisis intervention and there I learned about Structural Family Counseling. I know how to do crisis work and I know how to turn up flames, and occasionally I do. More and more, however, I'm drawing on more of my individual stuff and just listening to where people are. These are things my family training didn't incorporate.

Huber: What did your family-counseling training incorporate by contrast?

Brewster: I was taught in my family training to read the system and ask questions about the system. I wasn't taught to just listen to individuals and to what they were each saying. In learning about listening, I feel that my work has changed. I sit longer and make sure I'm hearing what people are saying to me. I think I make a better connection with my clients.

Huber: It sounds like you're assuming an integration, or combination of both individual and systemic approaches, which might not have been the case earlier in your career.

Brewster: That's right, and I view that as a developmental process as I mature as a counselor.

Huber: You wrote in the article that counselors who specialize in working with families need to adapt to the "special rhythms" of family treatment, that being evening or weekend appointments, for example. Can a family counselor in private practice expect to have nightly dinners with his or her family?

Brewster: My initial response is "No," but I suppose that at some point you can take a position about that. I've taken a position that I don't work weekends. I used to work Saturday mornings for a long, long time. I now work two evenings a week until 10 p.m. and one evening until 8:30 p.m. Because I am out three evenings a week, I volunteer in my children's school for a couple of hours in the morning, and I try to make other time to see them some during the day. Families, particularly in this economy, can't come during the day. I find I have responded to this predicament in several ways. I'm either seeing families at night or I'm seeing them every so often, like once a month. Some come during the day and I encourage that, but I have not figured out a way at this point in my life to do a daytime practice and still see families.

TFPC: Two nights a week until 10 p.m. It sounds like you have found yourself having to adapt to those special rhythms.

Brewster: If I just saw individuals I could probably cut way back on my nighttime hours. But for me to work the way I want to work, with couples and families, I have to maintain evening hours.

Huber: In your article, you presented the idea of the "daily horoscope," the idea that counselors' practices reflect their own interests and where they are at in their own life cycles. I personally found that concept quite intriguing. How has that concept played out in your own personal and professional experience?

Brewster: When it became clear that I wasn't going to have a son, low and behold my practice started to fill up with little boys, 7, 8, 9, and 10. I didn't go looking for them. They just came. I just thought that was a very interesting thing. This has arisen several times paralleling issues I have worked on in my own life.

Huber: The reason I think that I found it so intriguing was that, after reading your article and processing it a bit, I looked at my own practice and recalled similar things having occurred. I never had paid attention to it. Several of my colleagues with whom I have since shared the concept have responded with similar identifications.

Brewster: Yes, it's an interesting concept that warrants further reflection and perhaps research. It's also a concept that conveys the importance of being aware of the issues you are experiencing in your own life and using them to enrich your work.

Huber: If you had to offer advice for an individually trained counselor in private practice who was seeking to transition to a family-counseling practice, what might you say?

Brewster: I think that anyone who does family work needs to have support such as colleagues with whom to share your ideas. Being in private practice can be very lonely. While that is true for individual counselors, too, I find it takes much greater discipline to think and practice systemically. It becomes very easy to get out of sync, and a support network of colleagues can help one maintain that sync. I also think that it's important to do Bowen Family-Systems work with one's own original family. I know not everyone would agree with that.

Huber: That's something you found to be particularly true for yourself and perhaps colleagues you associate with?

Brewster: Yes, I think it is most helpful in maintaining a clear picture of who I am and how this impacts on those I see in counseling.

Huber: From your experiences and those of colleagues you interact with, what predictions might you have relative to the future of family counseling in private practice?

Brewster: I think that there is so much in the air right now about families, and I think that it has taken 10 or 20 years for family counseling to be readily recognized by people. Family counseling is more mainstream than it used to be, and I think that in the future more people will be seeking it out. Further, I believe that they will seek it out as a means of health maintenance in addition to using it as a vehicle for resolving problems.

Huber: So it may be easier for a family counselor entering private practice today than it might have been 10 years ago?

Brewster: Yes, and I think the primary reason is because family counseling is more mainstream, but also there is so much more publicity given to abuse, addiction, and the like in families. As a consequence, families are becoming more educated as to the value of family counseling.

Huber: So, that's something you would see increasing more in the future. Even given some of those cautions you earlier offered, it appears that you would see a private practice having a major portion devoted to working with families to be a potentially lucrative practice in the future.

Brewster: Yes. I would say in my practice I see a third families, a third couples, and a third individuals.

Huber: Any other comments relative to family counseling and private practice?

Brewster: This might engender disagreement, but in the future I believe private practitioners are going to be paid out of pocket. Given the rise of HMOs and the like, I don't believe insurance will cover private practice in the future. You will need to be good and then people will come to you.

Huber: While family counseling might be more of a mainstream approach that people will seek out, people are going to have to pay for it out of pocket.

Brewster: I doubt in the future that insurance companies will pay for the private practice provision of it. And counselors might do better work as a result. I see that as being where we're heading.

Huber: That's an interesting position to assert.

Brewster: I don't know if you wanted to hear that or not.

Huber: That has possibilities for two different directions. It may be discouraging to some. As you said, though, effective counselors will have clients. And they won't have to deal with many of the hassles and concerns that insurance raises. Anything else you would like to say?

Brewster: I think that if someone is going to begin a private practice highlighting family counseling, he or she needs to be clear about the approach and its potential limitations and contributions. I think the beginning family counselor in private practice needs to do several kinds of things: long-term counseling, short-term counseling, crisis management, and so on. More experienced counselors can specify their area of work and say, "This is what I do." I would encourage that whatever path is chosen, it eventually be unique to themselves.

Huber: And so maybe the successful practitioner is the one who ultimately recognizes the uniqueness of his or her practice and emphasizes that uniqueness?

Brewster: Right. He or she needs to say to clients, "This is what I have to offer you."

Huber: That appears to be a great place for us to close. Thank you very much for your time and willingness to share your perspective and experiences.

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TRANSITIONING FROM INDIVIDUAL TO FAMILY COUNSELING, the second volume in The Family Psychology and Counseling Series, examines the various challenges professional counselors face when changing from an individual client orientation to a family systems perspective. Professionals in the field provide interventions and counseling techniques that target improvement in overall family functioning, as well as individual family member symptoms. Also discussed are the various contexts in which family counseling occurs, including school, health care, private practice, and business settings.

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ABOUT THE MONOGRAPH EDITOR

Charles H. Huber, Ph.D. is on the faculty of the Department of Counseling and Educational Psychology at New Mexico State University. He maintains a private practice with Associates for Marriage and Family Therapy in Las Cruces, and is a licensed psychologist in the states of Connecticut, Florida, and New Mexico.

ABOUT THE SERIES EDITOR

Jon Carlson, Psy.D., Ed.D. is Distinguished Professor at Governors State University in University Park, Illinois and Director of the Lake Geneva Wellness Clinic in Wisconsin. He is also the editor of *Individual Psychology: The Journal of Adlerian Theory, Research and Practice* and *The Family Journal.*

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5999 Stevenson Avenue
Alexandria, VA 22304-3300